****DERMATOLOGY CENTER

1452 Waukegan Road Glenview IL 60025 (847) 832-1185

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Last) (First) (MI)

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Today’s Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| PAST MEDICAL HISTORY: (Please circle all that apply) |

Anxiety

Arthritis

Asthma

Atrial Fibrillation

Autoimmune

Bone Marrow Transplant

Benign Prostatic Hyperplasia

Breast Cancer

Colon Cancer

COPD

Coronary Artery Disease

Depression

Diabetes

End Stage Renal Disease

GERD

Hepatitis

High Blood Pressure

HIV/AIDS

High Cholesterol

Hyperthyroidism

Hypothyroidism

Leukemia

Lung Cancer

Lymphoma

Prostate Cancer

Radiation Treatment

Seizures

Stroke

NONE

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| PAST SURGICAL HISTORY: (Please circle all that apply) |

Appendix Removed

Bladder Removal

Breast Biopsy (Right, Left, Bilateral)

Breast Implants / Breast Reduction

Lumpectomy (Right, Left, Bilateral)

Mastectomy (Right, Left, Bilateral)

Colectomy: Colon Cancer Resection

Colectomy: Diverticulitis

Colectomy: IBD

Coronary Artery Bypass

Gallbladder Removed

Heart Transplant

Heart: Biological Valve Replacement

Heart: Mechanical Valve Replacement

Joint Replacement within Last 2 Years

Kidney Biopsy (Nephrectomy)

Kidney Removed (Right, Left)

Kidney Stone Removal

Kidney Transplant

Hysterectomy: Fibroids

Hysterectomy: Uterine Cancer

Ovaries Removed: Cyst

Ovaries Removed: Endometriosis

Ovaries Removed: Ovarian Cancer

Prostate Biopsy

Prostate Removed: Prostate Cancer

Spleen Replacement

TURP (Prostate Removal)

NONE:

Other:

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| SKIN DISEASE HISTORY: (Please check circle all that apply) |

Acne Dry Skin Poison Ivy

Actinic Keratosis Eczema Precancerous Moles

Asthma Flaking or Itchy Scalp Psoriasis

Basal Cell Skin Cancer Hay Fever/Allergies Squamous Cell Skin

Blistering Sunburns Melanoma Cancer

NONE Other: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Wear Sunscreen?  **YES** / **NO** (circle one) If Yes, What **SPF**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| MEDICATIONS |

Are you currently taking any prescribed medications?  **YES** / **NO** (circle one)

(If yes, please enter medication with **dose** and **frequency**)

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| ALLERGIES: Please list all allergies or NONE if applicable |

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| SOCIAL HISTORY (circle all that apply) |

**CIGARETTE USE**  **ALCOHOL USE**

Never Smoked None

Currently Smokes Cigarettes Less Than (1) Drink per Day

Currently Smokes Cigars (1-2) Drinks per Day

Former Smoker /Quit: \_\_\_\_\_\_\_\_\_\_\_\_\_ (3 or More) Drinks per Day

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| FAMILY HISTORY: |

Specify which FAMILY MEMBER below:

Diabetes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Melanoma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| PREFERRED PHARMACY |

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| PREFERRED LANGUAGE |

PREFERRED LANGUAGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RACE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ETHNIC GROUP: ­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| REVIEW of SYSTEMS: Are you experiencing any of the following? (Please check (√) Yes or No |
| **Symptom** | **Yes** | **No** |
| Problems with Healing |  |  |
| Problems with Scarring (Hypertrophic or Keloid) |  |  |
| Dry Skin |  |  |
| Hay Fever |  |  |
| Hair Loss |  |  |
| Immunosuppression |  |  |
| Fever or Chills |  |  |
| Night Sweats |  |  |
| Unintentional Weight Loss |  |  |
| Unintentional Weight Gain |  |  |
| Anxiety |  |  |
| Depression |  |  |
| Sore Throat |  |  |
| Muscle Weakness |  |  |
| Headache |  |  |
| Joint Aches |  |  |
| Muscle Aches |  |  |
| Abdominal Pain |  |  |
| Blurry Vision |  |  |
| Bloody Stool |  |  |
| Rash |  |  |
| Problems with Bleeding |  |  |

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| ALERTS: (Please check (√) all that apply) | √ |
| Allergy to Adhesive |  |
| Allergy to Lidocaine |  |
| Allergy to Topical Antibiotics |  |
| Artificial Heart Valve |  |
| Blood Thinners |  |
| Defibrillator |  |
| MRSA |  |
| Pacemaker |  |
| Require Antibiotics prior to a Surgical Procedure |  |
| Rapid Heart Beat with Epinephrine |  |
| Are you Pregnant or Currently Trying to get Pregnant? |  |