CENTRAL COAST DERMATOLOGY
215-B STATION STREET
JACKSONVILLE, NC 28546
Office (910) 577-2334 Fax (910) 577-2363

REVIEW OF SYSTEMS

NAME _____ DATE _____ MALE _____ FEMALE _____

DO YOU HAVE ANY OF THE FOLLOWING:

YES NO Asthma
YES NO Hay Fever/Seasonal Allergies
YES NO History of TB or Exposure to TB
YES NO History of Heart Attacks
YES NO High Blood Pressure
YES NO Night Sweats
YES NO Depression
YES NO Seizures
YES NO Hallucinations
YES NO Cancer. If yes, which type _____

_____

YES NO Have you ever had psychiatric help?
YES NO History of Hepatitis
YES NO Extended muscle pain or weakness
YES NO Arthritis
YES NO Painful Urination
YES NO Diabetes
YES NO Thyroid Disease
YES NO Sensitivity to Cold
YES NO History of Eczema
YES NO History of Psoriasis
YES NO History of Blood Transfusions
YES NO History of Intravenous Drug Abuse
YES NO Have you ever been tested for HIV? If yes, what were your results
YES NO Do you smoke? How much _____
YES NO Do you drink Alcohol? How much _____
YES NO Any Family History of Skin Cancer or Other Cancer? If yes, please describe

_____

FOR WOMEN ONLY:

YES NO Do you have abnormal periods?
YES NO Do you have excessive body hair?
YES NO Could you be pregnant?
YES NO Are you planning to become pregnant?

Have you ever had any of the following: (If yes, please explain)	Yes	No
Reactions or allergies to local anesthetics such as those used by the dentist?		
Bleeding disorders, frequent nosebleeds, easy bruising or bleeding longer than most people when cut?		
Have you ever fainted?		
Do cuts on your skin heal with normal scars?		
Are you allergic or have you had a "bad reaction" to any substance applied to your skin?		
Have you had previous cosmetic surgery?		

If yes, please list _____

Local Doctor: Name: _____

Address: _____

City/State/Zip _____ Phone: _____

Dentist: Name _____

Address: _____

City/State/Zip _____ Phone: _____

Please list the medications you are now taking (including birth control pills and vitamins):

_____ How long _____ How long _____

_____ How long _____ How long _____

Allergies to Medicines Yes _____ No _____ If yes, please list _____

Previous Admissions to a Hospital	Procedure	Year (Approx)

What type of problem will you be consulting the Doctor for today? _____

How long has the problem existed? _____

Please state the location of the problem _____

Is there anything else you would like to tell us about your past or present medical history? _____