

REVIEW OF SYSTEMS / MEDICAL HISTORY

(New Patient Visit)

Name: _____ Date of Birth: ____/____/____
Last First Middle

History or current problem with any of the following? (Please check all that apply)

| | | | | | |
|---|--|-----------------------------|--|--|--|
| Problems with bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Menstrual Changes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergy to Adhesive | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Problems with healing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Muscle Weakness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergy to Lidocaine | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Problems with scarring <i>(hypertrophic or keloid)</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neck Stiffness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergy to topical antibiotic ointments | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Abdominal Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Night Sweats | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rash/Hives | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Joints in the last 2 yrs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bloody Stool/Urine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Thinners | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blurry Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | Defibrillator | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sleeplessness | <input type="checkbox"/> Yes <input type="checkbox"/> No | MRSA | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sore Throat | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Currently pregnant or planning a pregnancy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Unintentional Weight loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | Premedication prior to procedures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fever or Chills | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Candidiasis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rapid heartbeat with epinephrine | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Grey Discoloration of Skin | <input type="checkbox"/> Yes <input type="checkbox"/> No | Wheezing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Transplant | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Red Eye | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tearing | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Immunosuppression | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Joint Aches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Elevated Blood Sugar | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Joint Replacement | <input type="checkbox"/> Yes <input type="checkbox"/> No | Uncontrolled Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Have you had any of the following conditions? (Please check all that apply)

| | | | |
|---|--|--|--|
| <input type="checkbox"/> Acne <input type="checkbox"/> Blistering Sunburns <input type="checkbox"/> Dry Skin <input type="checkbox"/> Eczema <input type="checkbox"/> Flaking or Itchy Scalp <input type="checkbox"/> Hay Fever/Allergies <input type="checkbox"/> Psoriasis <input type="checkbox"/> Poison Ivy | <input type="checkbox"/> Actinic Keratosis (pre-skin cancer) <input type="checkbox"/> Precancerous Moles <input type="checkbox"/> Squamous Cell Skin Cancer <input type="checkbox"/> Basal Cell Skin Cancer <input type="checkbox"/> Melanoma Year _____ <input type="checkbox"/> Other _____ | Have you ever tested positive for TB? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Do you have any environmental allergies? If yes, please list | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Are you allergic to any medications? If yes, please list | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Have ever tested positive for hepatitis? If yes, please list which type | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Are you currently taking any of the blood thinners? (Check from listed below)

| | | | | | |
|--|---|----------------------------------|--|---|--|
| Hypertension: Have you been diagnosed with high blood pressure/hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a family history of melanoma? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which relative(s)? | Vaccinations: Have you received your flu vaccination for the current year? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you received your pneumonia vaccination? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Cilostazol (Pletal) | <input type="checkbox"/> Coumadin (Warfarin) | <input type="checkbox"/> Dipyridamole (Aggrenox) |
| | | <input type="checkbox"/> Effient | <input type="checkbox"/> Eliquis | <input type="checkbox"/> Pentoxifylline (Trental) | <input type="checkbox"/> Plavix (Clopidogrel) |
| | | <input type="checkbox"/> Pradaxa | <input type="checkbox"/> Ticagrelor (Brilinta) | <input type="checkbox"/> Ticlodipin (Ticlid) | <input type="checkbox"/> Xarelto |

REVIEW OF SYSTEMS / MEDICAL HISTORY

(New Patient Visit)

| |
|-------------------------------|
| Date of Birth: ____/____/____ |
|-------------------------------|

| Medications (List All) | | | |
|---------------------------|--------|-----------|-------|
| Medication | Dosage | Frequency | Route |
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| Medical Problems (Please list any medical problems for which you are regularly treated) |
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| Surgical History | |
|------------------|------|
| Surgery | Date |
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Signature: _____ Date: _____

Printed Name: _____