

Advanced Dermatology Associates
Review of Systems, Past Medical, Family and Social History Form

GENERAL

Fever	<input type="radio"/> Yes	<input type="radio"/> No
Weight Loss / Gain	<input type="radio"/> Yes	<input type="radio"/> No
Extreme Fatigue	<input type="radio"/> Yes	<input type="radio"/> No
Night sweats	<input type="radio"/> Yes	<input type="radio"/> No

ENDOCRINOLOGY

Excessive thirst	<input type="radio"/> Yes	<input type="radio"/> No
Insomnia	<input type="radio"/> Yes	<input type="radio"/> No

LUNGS/RESPIRATORY

Shortness of breath	<input type="radio"/> Yes	<input type="radio"/> No
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CARDIOLOGY

Chest pain	<input type="radio"/> Yes	<input type="radio"/> No
Palpitations	<input type="radio"/> Yes	<input type="radio"/> No
Ankle swelling	<input type="radio"/> Yes	<input type="radio"/> No
Pacemaker	<input type="radio"/> Yes	<input type="radio"/> No

PSYCHOLOGY

Depression	<input type="radio"/> Yes	<input type="radio"/> No
Suicidal ideation	<input type="radio"/> Yes	<input type="radio"/> No
Anxiety	<input type="radio"/> Yes	<input type="radio"/> No

MUSCULOSKELETAL

Joint pain	<input type="radio"/> Yes	<input type="radio"/> No
Back pain	<input type="radio"/> Yes	<input type="radio"/> No

Ear/Nose/Throat

Nose bleed	<input type="radio"/> Yes	<input type="radio"/> No
Ringling in ears	<input type="radio"/> Yes	<input type="radio"/> No
Difficulty swallowing	<input type="radio"/> Yes	<input type="radio"/> No

NEUROLOGY

Headache	<input type="radio"/> Yes	<input type="radio"/> No
Tingling/Numbness	<input type="radio"/> Yes	<input type="radio"/> No
Seizures	<input type="radio"/> Yes	<input type="radio"/> No

Eyes

Irritation of the Eyes/ Eyelids	<input type="radio"/> Yes	<input type="radio"/> No
Blurred Vision	<input type="radio"/> Yes	<input type="radio"/> No

GASTROENTEROLOGY

Diarrhea	<input type="radio"/> Yes	<input type="radio"/> No
Constipation	<input type="radio"/> Yes	<input type="radio"/> No
Eating Problems	<input type="radio"/> Yes	<input type="radio"/> No

HEMATOLOGY/LYMPH

Bleeding	<input type="radio"/> Yes	<input type="radio"/> No
Sweating	<input type="radio"/> Yes	<input type="radio"/> No
Swollen glands	<input type="radio"/> Yes	<input type="radio"/> No

Urinary

Difficulty urinating	<input type="radio"/> Yes	<input type="radio"/> No
Frequency	<input type="radio"/> Yes	<input type="radio"/> No
Burning	<input type="radio"/> Yes	<input type="radio"/> No

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Allergy/Immunology

Dust Yes No
 Ragweed Yes No
 Molds Yes No
 Pollen Yes No

Skin

Itchiness Yes No
 Skin Allergies Yes No
 Hair loss Yes No
 Lumps/Growths Yes No
 Rashes Yes No
 Changing-Moles/Lesions Yes No

Pregnancy Issues

Currently Pregnant Yes No
 Currently Breast feeding Yes No
 Currently on birth control Yes No

Social History

Smoker Yes No
 > 1 pack/day < 1 pack/day
 Alcohol Yes No
 Daily Weekly Monthly Yearly
 Recreational drug use Yes No
 Sexually active Yes No
 Lives alone Yes No
 Regular exercise Yes No
 Regularly uses sunscreen Yes No
 Tanning bed use Yes No
 At least 1 blistering sunburn Yes No

Past Medical History

History of skin cancer Yes No
 Skin Cancer Type N/A Basal Cell Squamous Cell
 Melanoma Other
 Skin disease Yes No

Family History

Family history of Skin Cancer Yes No
 Mother Yes No
 Father Yes No

 Family history of Skin Disease Yes No
 Mother Yes No
 Father Yes No

Name: _____ Signature: _____ Date: _____