

NEW ENGLAND DERMATOLOGY & LASER CENTER
REVIEW OF SYSTEMS

For Office use only

Chart #: _____

Initial Hx

Updated Hx

NAME: _____ DATE: _____

Who is your PRIMARY CARE PHYSICIAN?

Have you ever been a patient in our office? Yes No If yes, how long ago? _____

What WAS the reason? _____

What IS the reason for your visit today? _____

Are you ALLERGIC or have you had ADVERSE REACTIONS to any MEDICATIONS, FOODS, LATEX OR RUBBER PRODUCTS? _____ Yes _____ No

If yes, please list and explain. _____

List ALL MEDICATIONS, PRESCRIPTIONS, and/or NON-PRESCRIPTION (including herbal medications, aspirin, birth control pills, allergy shots, vitamins, laxatives, pills for headache, arthritis, nerves, sleeping, pain, etc.) that you take daily: _____ No medications

Please **CIRCLE** any of the following **MEDICAL PROBLEMS** you have or have had. List any others.

HEART: High blood pressure, angina, heart attack, heart murmur, irregular heart beat, pacemaker.

LUNG: Bronchitis, emphysema.

STOMACH, BOWEL, or LIVER: Ulcers, colitis, diverticulitis, irritable bowel.

KIDNEY DISEASE:

GYNECOLOGICAL: Irregular menstrual cycles.

METABOLIC: Diabetes, thyroid problems.

NEUROLOGIC: Migraine headache, convulsions, stroke.

MENTAL HEALTH COUNSELING: Was medication prescribed? _____ Yes _____ No

BLOOD: Bleeding problems, anemia.

ARTHRITIS: Rheumatoid, osteoarthritis, psoriatic, lupus.

BONE/JOINT IMPLANTS: Artificial knee, hip, metal pins, etc.

VASCULAR: Varicose veins or blood clots in legs.

EYES: Glasses, contact lenses, glaucoma, cataracts, lens implants.

EARS: Hearing aid.

ALLERGIES: Asthma, hayfever, sinus problems, hives.

CANCER: Type:

Treatment: Surgery, radiation, chemotherapy.

Year of treatment:

Please Turn Over

OTHER DISEASES:

List any SURGERY you have had. _____ No surgery.

After injury or surgery, have your scars healed satisfactorily? Yes No

Have you or any family members had bleeding problems with dental procedures or surgery? Yes No

Have you ever had a reaction to locally injected anesthesia {Novocaine/Xylocaine} such as that which you may receive at the dentist? If yes, please explain. Yes No

Have you had skin reactions to bandaids, adhesive tape, antibiotic ointments or topical creams? Yes No

Have you ever fainted? Yes No

Prior to dental procedures or surgery, have you been advised to take antibiotics because of a heart problem, artificial joint implant, or other reason? Yes No

Please circle skin type:

- I Always burn, never tan
- II Always burn, but sometimes tan
- III Sometimes burn, but sometimes tan
- IV Never burn, always tan

Please CHECK any skin problems you HAVE or have HAD.

| | |
|------------------|----------------------------|
| _____ Eczema | _____ Warts |
| _____ Psoriasis | _____ Growth removed |
| _____ Cold sores | _____ Skin cancer/melanoma |
| _____ Frostbite | _____ Other |

Have your brothers, sisters, or parents had any of the following? Please CHECK.

| | |
|------------------------------------------------|----------------------------|
| _____ Asthma, hayfever, sinus problems, hives. | _____ Frostbite |
| _____ Eczema | _____ Warts |
| _____ Psoriasis | _____ Skin cancer/melanoma |
| _____ Severe acne | _____ Other |

Do you smoke? Yes No

Do you drink alcohol? Yes No

Thank you for your cooperation in completing the above questionnaire

{Patient or Guardian Signature}

For office use:

The above PATIENT PROFILE was reviewed with the patient.

and/or _____ by _____