



# 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)**

<b>Hypertension:</b> Have you been diagnosed with high blood pressure/hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Do you have a family history of melanoma?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which relative(s)? _____	<b>Vaccinations:</b> 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

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Medications (List All)			
Medication	Dosage	Frequency	Route

Medical Problems (Please list any medical problems for which you are regularly treated)

Surgical History	
Surgery	Date

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_