

DERMATOLOGY SPECIALISTS OF NORTH ATLANTA, P.C.
PATIENT HISTORY FORM

Patient Name _____ Name you prefer to be called _____
Marital Status _____ Number of children _____ Occupation _____

HISTORY OF PRESENT ILLNESS

Please describe the reason for your visit _____
Please list prior treatments for this condition _____
When was this condition first noted? _____
What areas of your face or body are involved? _____
Is the condition painful? _____ Is the condition worsening or improving? _____

SKIN TYPE AND SKIN CANCER RISK FACTORS

What is your ethnic origin? _____ Do you sunburn easily? _____ Do you tan easily? _____
What is your natural hair color? _____ What is your eye color? _____
Has anyone in your family had melanoma? _____ Do you have a history pre-cancers or skin cancer?
If so, list types of skin cancer and year _____
Do you have a history of abnormal moles? _____ Do you have freckling of your upper back? _____
Did you have more than 3 blistering sunburns as a child? _____ Do you have numerous moles? _____
Have you ever had an outdoor job? _____ Have you ever used tanning beds? _____

FEMALE MENSTRUAL HISTORY

Last Menstrual Period _____ Are you pregnant? _____ Age at menopause? _____
Are you trying to get pregnant? _____ Are you sexually active? _____ What type of contraception are
you using? _____ Have you ever been pregnant? _____ Number of children _____

ALLERGIES TO MEDICATIONS

Please list all medication allergies and type of reactions _____

MEDICATIONS

Please list ALL prescription medications you take or use including over the counter pills and creams:

PAST MEDICAL HISTORY Please indicate if you have ever had any of these conditions:

Cardiovascular: _____ Artificial Joints/Valves _____ Blood Clot _____ High Blood Pressure (Hypertension)
_____ High Cholesterol (Hypercholesterolemia) _____ Heart Disease _____ Pacemaker _____ Stroke
Childhood Disease: _____ Chicken Pox
Dermatological: _____ Accutane _____ Atopic Dermatitis _____ Fillers (injected) _____ Genital Warts (HPV)
_____ Fever Blisters _____ Herpes, Oral _____ Herpes, Genital _____ Psoriasis _____ Shingles
Endocrine: _____ Diabetes _____ Hormone Problems _____ Thyroid Disease
Gastrointestinal: _____ Hepatitis _____ Inflammatory Bowel Disease _____ Liver Disease _____ Ulcer
Genitourinary: **Female:** _____ Abnormal Pap Smear _____ Infertility _____ Miscarriage **Male:** _____ Prostate
Renal/Kidney: _____ Dialysis _____ Kidney Disease _____
Head, Eyes, Ears, Nose, Throat: _____ Cataracts _____ Dentures _____ Glaucoma _____ TMJ Disease
Hematologic/Lymphatic: _____ Anemia (Low Blood Count) _____ Bleeding Disorder _____ Cancer (Type)

Immunologic: ___ AIDS/HIV ___ Auto-Immune Disease ___ Epstein-Barr ___ Lupus ___ Sarcoid
Musculoskeletal: ___ Arthritis ___ Metal Implants ___ Osteoporosis
Neurological: ___ Migraine Headaches ___ Neurological Disease ___ Seizures ___ Stroke
Psychiatric: ___ ADHD ___ Alcoholism ___ Anxiety ___ Body Dysmorphic Disorder
 ___ Depression ___ Drug Addiction ___ Learning Disability ___ Mental Retardation ___ OCD
 ___ Panic Attack ___ Schizophrenia
Respiratory: ___ Asthma ___ Hay Fever ___ Respiratory Disease ___ Tuberculosis

PAST SURGERIES

TYPE OF SURGERY AND OUTCOME	YEAR

FAMILY HISTORY

RELATION	AGE	DISEASE	AGE AT DEATH	CAUSE OF DEATH

HEALTH HABITS AND GENERAL INFORMATION

Do you drink alcohol? ___ How many drinks and how often? _____
 Do you use tobacco? ___ How much do you smoke and for how long? _____
 Have you ever had a sexually transmitted disease? ___ List types _____
 Have you ever taken illegal drugs? ___ List types _____
 Have you had any cosmetic procedures done? ___ List dates and types _____

 Do you have any cosmetic concerns about your skin? Please list _____
 Have you ever experienced depression? ___ Have you ever attempted suicide? _____
 Were you referred to us by your doctor? ___ If so, please list your physician's name, address, and telephone _____
 If you were not referred by your physician, how did you hear about us? _____
 Please list all family members treated by Dr. Cole _____

REVIEW OF SYSTEMS *If you have RECENTLY experienced the following symptoms, please check:*

ALLERGIC

- ___ Allergies to environment
- ___ Allergies to food
- ___ Allergies to products
- ___ Eye watering
- ___ Runny Nose
- ___ Sinus problems
- ___ Sneezing
- ___ Stuffy nose

CARDIOVASCULAR

- ___ Change in color of hands & feet
- ___ Chest pain
- ___ Low blood pressure
- ___ Palpitations
- ___ Poor circulation
- ___ Rapid or irregular heartbeat
- ___ Spider or varicose veins
- ___ Swelling of legs

CONSTITUTIONAL

- ___ Chills
- ___ Dizziness
- ___ Fatigue
- ___ Fever
- ___ Headaches
- ___ Insomnia
- ___ Night sweats
- ___ Weight change

EAR, NOSE, THROAT

- Difficulty opening mouth wide
- Difficulty swallowing
- Ear ache
- Ear problems
- Hearing loss
- Hoarseness
- Ringing in ears
- Sores in mouth, nose or ears
- Tooth or gum problems
- White patches in mouth

GASTROINTESTINAL

- Abdominal pain
- Abdominal distension
- Appetite change
- Blood in stool
- Bowel changes
- Constipation
- Diarrhea
- Heartburn
- Hemorrhoids
- Hepatitis carrier
- Laxative use
- Nausea
- Rectal bleeding
- Vomiting
- Ulcer
- Yellowing of skin

INTEGUMENTARY/SKIN

- Acne
- Acne scarring
- Blisters
- Brown spots
- Changing mole
- Dandruff
- Discoloration
- Eczema
- Facial redness/flushing
- Hair loss
- Herpes, oral
- Hives
- Irritated skin

- Moles-irregular or dark
- Sagging of skin
- Sensitive skin
- Skin cancer concerns
- Skin sores
- Stretch marks
- Sun damage
- Ulcers of skin
- Wrinkles

ENDOCRINE

- Bowel changes
- Cold intolerance
- Dry hair
- Dry skin
- Excess hair
- Excessive thirst
- Hair loss
- Heat intolerance
- Urinary frequency
- Weight change

GENITOURINARY

- Blood in urine
- Breast lump or problem
- Burning with urination
- Currently pregnant
- Discharge
- Genital warts
- Growth or sore in genital area
- Herpes, genital
- Herpes, oral
- Hot flashes
- Menstrual abnormalities
- Painful intercourse
- Partner with STD
- Prostate problems
- Recent rape or sexual abuse
- Urinary incontinence

MUSCULO-SKELETAL

- Arthritis
- Back pain
- Heel pain
- Hip pain
- Joint redness
- Joint pain
- Joint stiffness
- Joint swelling
- Muscle pain
- Neck pain
- Shoulder pain
- Stiffness in AM
- Weakness
- Itchy skin

PSYCHIATRIC

- Angry feelings
- Addiction to drugs
- Anxious feeling
- Crying frequently
- Depression
- Irritability
- Panic attacks
- Sadness
- Stress (recent increase)
- Suicide thoughts

EYES

- Blurred vision
- Contacts
- Dry eyes
- Eye problems
- Glasses
- Night vision problems
- Pain in the eyes
- Photosensitivity
- Red eyes
- Vision problems

HEMATOLOGY/CANCER

- Anemia
- Bleeding disorder
- Bleeding problems
- Bleeding tendency
- Bruise easily
- Calf pain/swelling
- Frequent nose bleeds
- Increased time to stop bleeding
- Swollen lymph nodes
- Transfusion
- Cancer (type) _____

NEUROLOGIC

- Aura
- Burning
- Confusion
- Dizziness
- Facial tic
- Fainting
- Hypersensitivity
- Numbness
- Paralysis
- Tingling
- Tremors
- Weakness (focal)

RESPIRATORY

- Breathing difficulties
- Chest tightness
- Cold-like symptoms
- Cough
- Flu-like symptoms
- Recent exposure to TB
- Shortness of breath
- Wheezing