**Nia K. Terezakis, M.D.**

**Patricia R. Hickham, M.D. Elizabeth B. Grieshaber, M.D.**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/201\_\_\_\_

Reason for Doctor’s Visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of physician who is usually responsible for the patient’s medical care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete NO (N) or YES (Y) for each of the following **regarding the patient for the last 3 months**:

**Skin**: **General Health**: **Eyes**:

N Y Changing/Bleeding Moles N Y Fever/Chills N Y Itchy/Red/Dry Eyes

N Y Hives N Y Fatigue/Excess Tiredness N Y Blurry Vision (new onset)

N Y Itching/Rashy/Dry Skin N Y Weight Gain/Loss N Y Glaucoma

N Y Excessive Hair Growth/Loss **Pulmonary**: **Musculoskeletal**:

N Y Sunburn/Blistering N Y Shortness of Breath N Y Joint pain/Arthritis/Muscle Aches

**ENT & Allergy**: **Cardiovascular**: **Gastrointestinal**:

N Y Oral Ulcers N Y Varicose Veins N Y Nausea/Vomiting/Diarrhea

N Y Fever Blisters/Chapped Lips N Y Leg Swelling N Y Jaundice/Yellowing Skin

N Y Allergies/Sinus Problems **Neurology & Psychology**: **Endocrinology**:

**Genitourinary**: N Y Seizures N Y Swollen Neck/Thyroid

N Y Burning on Urination N Y Headaches/Migraines N Y Easy Bruising

N Y Women: Possible Pregnancy N Y Depression/Anxiety

N Y Women: Breastfeeding

**Personal Medical History**:

List known medication allergies: | List of all patient’s medications: NONE

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NONE KNOWN | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Complete each of the following regarding **the patient’s skin**. Is there a history of:

N Y Atypical/Abnormal Moles N Y Acne N Y Keloids

N Y Precancers/Actinic Keratoses (AKs) N Y Psoriasis

N Y Skin Cancer: If yes, which type(s)? N Y Atopic Dermatitis/Eczema

Basal Cell Squamous Cell Melanoma N Y Multiple Sunburns

Site/Year:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ N Y Tanning Bed use: How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle or list patient’s past and current **Medical Conditions: NONE**

High Blood Pressure Diabetes Asthma Glaucoma Heart Problems Lupus Cancer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immune Deficiency HIV Hepatitis B / C Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family** **History**: Circle or list any known family history of the following:

Abnormal Moles Acne Psoriasis Atopic Dermatitis (Eczema) Asthma Keloids Lupus Diabetes

Skin Cancer: Precancers (AKs) Basal Cell Squamous Cell Melanoma Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social** **History**: Highest Education:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where currently in school:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol use: NO YES \_\_\_\_\_\_\_\_\_\_drinks/day week month

Tobacco use: NO YES \_\_\_\_\_\_\_\_\_\_packs/day x \_\_\_\_\_\_\_\_\_\_\_\_years

Drug use: NO YES, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form was filled out by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr. Initial/Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_