OMG Dermatology

Please Complete the Following Medical Information

Name _____ DOB _____ Date _____

Age _____ Sex ☐ M ☐ F You were sent by: ☐ M.D.: _____ ☐ Self/Friend

CC: Reason for todays visit: ☐ check up ☐ other: _____

HPI History of today's problem(s):

- LOCATION *(skin areas Involved):* _____
- DURATION *(How long has the problem been present?):* _____
- TIMING *(Was there any previous treatment?)* ☐ No ☐ Yes When? _____
- CONTEXT (Was a biopsy done?) ☐ No ☐ Yes ☐ biopsy done by referring MD ☐ Other: _____

Check all that apply regarding today's problem: ☐ none apply

• *QUALITY*
A change in:
- ☐ size
- ☐ color
- ☐ elevation
- ☐ hardness
- ☐ other _____

• *MODIFYING FACTORS*
A history of:
- ☐ X-ray treatments (Not routine dental or chest X-rays)
- ☐ Ultraviolet light treatments
- ☐ arsenic exposure / treatments
- ☐ chronic scar
- ☐ immunosuppression

• *ASSOCIATED*
- ☐ bleeding
- ☐ tingling
- ☐ pain
- ☐ ulceration
- ☐ infection
- ☐ itching
- ☐ other _____

• *SEVERITY*
- ☐ no symptoms
- ☐ occasional symptoms
- ☐ constant symptoms

ROS: check all that apply regarding your overall health and add any other important problems.

MEDICATION ALLERGIES: ☐ none List: _____

MEDICATIONS: ☐ none ☐ aspirin (last taken: _____) ☐ blood thinners (last taken: _____)

☐ other medications *(include birth control pills, vitamins, Motrin and natural herb products)* _____

PROBLEMS WITH LOCAL ANESTHESIA: ☐ none LIST: _____

• *SKIN*
- ☐ normal
- ☐ keloids
- ☐ poor healing
- ☐ other skin disorders: _____

• *CARDIOVASCULAR*
- ☐ normal
- ☐ angina
- ☐ artificial heart valve
- ☐ pacemaker
- ☐ hypertension
- ☐ heart attack (when?)

• *NEUROLOGICAL*
- ☐ normal
- ☐ stroke
- ☐ seizures
- ☐ other: _____

• *HEMATOLOGIC / LYMPHATIC*
- ☐ normal
- ☐ anemia
- ☐ bleeding problems
- ☐ enlarged lymph nodes

• *RESPIRATORY*
- ☐ normal
- ☐ asthma
- ☐ emphysema
- ☐ other lung problem: _____

• *PSYCHIATRIC*
- ☐ normal
- ☐ depression
- ☐ anxiety attacks
- ☐ other: _____

• *CONSTITUTIONAL SYMPTOMS*
- ☐ none
- ☐ unintentional weight loss
- ☐ fever
- ☐ other: _____

• *GASTROINTESTINAL*
- ☐ normal
- ☐ stomach ulcer
- ☐ colitis
- ☐ difficulty swallowing
- ☐ other GI problem: _____

• *ENDOCRINE*
- ☐ normal
- ☐ diabetes
- ☐ thyroid problems
- ☐ other: _____

• *EYES / EARS / NOSE / THROAT*
- ☐ normal
- ☐ glaucoma
- ☐ bearing aid
- ☐ cosmetic surgery _____

• *MUSCULOSKELETAL*
- ☐ normal
- ☐ arthritis
- ☐ artificial joint
- ☐ Is your physical activity limited? ☐ Yes ☐ No explain: _____
- ☐ Are you able to perform activities of daily living w/o assistance? ☐ Yes ☐ No
- ☐ other: _____

• *INFECTIONS*
- ☐ none
- ☐ hepatitis
- ☐ HIV / AIDS
- ☐ tuberculosis (T.B.)
- ☐ other: _____

PAST HISTORY: • *Previous Skin Cancer:* ☐ none LIST: _____

MAJOR ILLNESS OR HOSPITALIZATIONS: ☐ none LIST: _____

FAMILY HISTORY (SKIN CANCER): ☐ melanoma ☐ other skin cancer (basal cell or squamous cell) ☐ none LIST: _____

SOCIAL HISTORY: Occupation: _____ Language Used: ☐ English ☐ Other: _____

Do you wear: ☐ dentures ☐ glasses ☐ contact lens. • Marital Status: ☐ S ☐ M ☐ D ☐ W

Smoking: ☐ No ☐ Former ☐ Yes How many packs per day? _____ • Alcohol: ☐ No ☐ Social / occassional drinking only

Alcohol or drug problems / addictions: ☐ No ☐ describe: _____

Do you have problems with pain? ☐ No ☐ Yes describe: _____