SOUTHEASTERN DERMATOLOGY, PA

4390 Fayetteville Road
Lumberton, North Carolina 28358

NAME _____ CHART _____ DATE _____

REASON(S) for your visit today: _____

_____

_____

ALLERGIES Please LIST all allergies: _____

_____

_____

MEDICATIONS Please LIST all current medications: _____

_____

_____

_____

MEDICAL HISTORY

PAST MEDICAL HISTORY Please CIRCLE all that apply

Anxiety
Arthritis
Artificial joint(s)
Asthma
Atrial Fibrillation
Bleeding problems
Breast Cancer
Colon Cancer
Depression
Diabetes
GERD
Fibromyalgia
Hearing Loss
Heart Attack
Heart Disease
Hepatitis / Liver disease
High Blood Pressure
High Cholesterol
HIV / AIDS
Kidney disease
Leukemia
Lung cancer
Lung disease
Lymphoma
Prostate problems
Scarring problems
Seizures
Stroke
Thyroid disease
Tuberculosis (TB)
Valve Replacement

NONE OF THE ABOVE

OTHER _____

PAST SURGICAL HISTORY Please LIST all prior surgeries: _____

_____

_____

_____

_____ _____

Patient Signature Reviewing Nurse's Signature

_____ _____

Reviewed by Andrew A. Hendricks, MD
Crystal C. Edwards, PA-C

Date

SOUTHEASTERN DERMATOLOGY, PA

NAME _____ **CHART** _____ **DATE** _____

SKIN DISEASE HISTORY Please CIRCLE if you have a Personal History of:

Actinic Keratosis	Hay Fever / Allergies	Skin Cancer
Asthma	Melanoma	Squamous Cell Carcinoma
Basal Cell Carcinoma	Precancerous Moles	
Eczema	Psoriasis	

OTHER _____

Do you have a Family History of Melanoma?	YES	NO
Do you have a Family History of Skin Cancer?	YES	NO
Do you have a Family History of Psoriasis?	YES	NO
Do you have a Family History of Eczema?	YES	NO

IF YES, which relative? _____

PLEASE CIRCLE ALL THAT APPLY

Have you ever had difficulty stopping bleeding?	YES	NO
Do you require antibiotics prior to a surgical procedure?	YES	NO
Have you had an artificial joint replacement?	YES	NO
IF YES, when and what body locations? _____		
Do you have an artificial heart valve?	YES	NO
Do you have a pacemaker?	YES	NO
Do you have a defibrillator?	YES	NO

FEMALES: Please CIRCLE all that apply

Do you still have menstrual periods?	YES	NO
Are you pregnant or currently trying to get pregnant?	YES	NO
What type of birth control do you use? _____		
Date of last menstrual cycle _____		
Are you breast feeding?	YES	NO

SOCIAL HISTORY Please CIRCLE all that apply

Illegal Drug Use?			YES	NO
Tobacco Use?	Never smoked	Former Smoker	Currently Smoke	Chew tobacco
Alcohol Use?	None	Social	Daily / Weekends	

_____ _____

Reviewed by: Andrew A. Hendricks, MD / Crystal C. Edwards, PA-C **Date**

SOUTHEASTERN DERMATOLOGY, PA

NAME _____ **CHART** _____ **DATE**_____

REVIEW OF SYSTEMS **CIRCLE if you PRESENTLY experience any of the following:**

GENERAL
Fever
Weight loss / gain
Fatigue
Night sweats
Other

EYES
Itching
Scratching sensation
Excess tears
Other

EAR / NOSE / THROAT
Bleeding
Pain
New Growths
Other

LUNGS
Cough
Shortness of breath
Other

HEART
Chest pain
Leg swelling
Leg pain with exercise
Other

ALLERGY
Allergy to Lidocaine / Novacaine
Topical Antibiotics

HEMATOLOIC
Bleeding Problems
Blood Clots
Anemia
Other

GASTROINTESTINAL
Abdominal Pain
Nausea
Bloody / Black stools
Other

GENITOURINARY
Painful / Difficulty with urination
Blood in urine / Change in urine
Other

MUSCULOSKELETAL
Bone pain / Fibromyalgia
Arthritis
Hip / Knee replacement
Other

SKIN (If not already mentioned)
New growths or nodules
Other changing skin lesions
Hair loss / Hair gain
Other

LYMPHATIC
Enlarged lymph nodes
Other

NEUROLOGIC
Burning sensation
Headaches
Weakness
Visual problems
Other

PSYCHIATRIC
Depression
Anxiety
Other

THYROID PROBLEMS

_____ _____
Patient's Signature **Date**

_____ _____
Reviewed by: Andrew A. Hendricks, MD / Crystal C. Edwards, PA-C **Date**