Arsenault DERMATOLOGY

Skin Care For Your Family

Date:

Review of Systems (1 of 2)

Patient Information: ______________________________ ____________

First **Middle** **Last Name** **Date of Birth**

Reason for today's Visit:

Medical History:

Current and/or past medical problems:

Current and/or past medical problems	Yes	No	If yes, explain
Weight Loss			
Skin			
Have you been diagnosed with Melanoma?			
If yes, did you have an X-Ray, Catscan, MRI or Petscan?			
Eyes			
Ears / Nose / Throat / Mouth			
Heart Disease / Heart Failure / Coronary Artery Disease (CAD) / High BP / High Chol			
Lung Disease / Chronic Obstructive Pulmonary Disease (COPD)			
Stomach / Bowel			
Kidneys			
Arthritis / Muscles / Joints			
Headaches / Seizures / Dizziness			
Psychological Disorders			
Thyroid / Diabetes			
Blood / Bleeding Disorders			
Did you receive the flu vaccine before this past flu season?			
Have you ever received the pneumonia vaccine?			
Females: Are you pregnant?			

Past Surgeries/Hospitalizations (if none, please type NONE)

Surgeries / Hospitalizations	Date	Notes

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OFFICES IN
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SARASOTA

ArsenaultDermatology.com

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Date: **Review of Systems (2 of 2)**

Patient Information: ______________________________ ____________

First	**Middle**	**Last Name**	**Date of Birth**

Social History:	Yes	No	if yes, explain
Do you live alone?			
Are you exposed to chemicals at work?			
If yes, which ones?			
What is your occupation?			
What are your hobbies?			

Family History:

Check conditions that have occurred in your family:

	N/A or Unknown	Parent	Sibling / Child
Skin Cancer			
Eczema			
Psoriasis			
Diabetes			
Autoimmune Disease			

Smoking Status:

Never been a smoker Current every day smoker Current sometimes smoker Current smokeless tobacco user

Former Smoker: When did you start?

When did you stop?

Alcohol Consumption:

How many times in the past year have you had 4 or more drinks in a day?

Less than Twice per Year ☐

More than Twice per Year ☐