SOUTHEASTERN DERMATOLOGY, PA

4390 Fayetteville Road
Lumberton, North Carolina 28358

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

Your Age: _____ **REASON(S) for your visit today:** _____
_____
_____

ALLERGIES Please LIST all allergies: _____
_____
_____

MEDICATIONS Please LIST all current medications: _____
_____
_____
_____

MEDICAL HISTORY

YOUR MEDICAL HISTORY **Please CIRCLE all that apply to you**

Anxiety Arthritis
Artificial joint(s)
Asthma
Atrial Fibrillation
Bleeding problems
Breast / Colon / Lung Cancer
Bronchitis / COPD / Lung disease
Depression / Mental Health Issues
Diabetes
GERD
Fibromyalgia
Hearing Loss
Heart Attack
Heart Disease
Hepatitis / Liver disease
High Blood Pressure
High Cholesterol
HIV / AIDS
Kidney disease
Leukemia
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** **Date**
Crystal C. Edwards, PA-C
Tiffany A. Clowers, PA-C

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 / Tiffany A. Clowers, PA-C **Date**

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

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

Acne	**Hay Fever / Allergies**	**Psoriasis**
Asthma	**Melanoma**	**Skin Cancer**
Basal Cell Carcinoma	**Pre-cancerous Areas**	**Squamous Cell Carcinoma**
Eczema	**Pre-cancerous Moles**	**Sunburn, single or multiple**

OTHER _____

FAMILY HISTORY Please CIRCLE if you have a Family History of:

			Family Member
Do you have a Family History of Skin Cancer / Melanoma?	**YES**	**NO**	_____ **Do**
you have a Family History of Psoriasis?	**YES**	**NO**	_____ **Do**
you have a Family History of Eczema?	**YES**	**NO**	_____ **Do**
you have a Family History of other Skin, Nail, or Hair Diseases	**YES**	**NO**	_____

IF YES, what type? _____

Do you have a Family History of Bleeding Disorders, Scarring, Arthritis, Cancer, Stroke, TB, Heart Disease Thyroid Disease, Lung Disease? If YES, please list _____

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 / pacemaker / 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

Occupation / Former Occupation _____

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

_____ _____

Patient's Signature **Date**

_____ _____

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