SIU DERMATOLOGY MEDICAL HISTORY

PLEASE BRING FORM WITH YOU AT TIME OF APPOINTMENT / DO NOT MAIL BACK

Affix label here

Patient name: _____

Reason for visit: _____

_____

Name of referring physician: _____

List any medications/foods you may be allergic to: _____

_____

List all medications, including non-prescription medications, you are currently taking:

_____

_____

Occupation (Previous if retired): _____

Do you use tobacco products?_____ If so, how much each day?_____

Do you consume alcohol?_____If so, how much each week?_____

Do you now have, or ever had diseases/disorders of the following:

Eyes/ears/ nose/throat	☐ No	☐ Yes	Blood system/clotting	☐ No	☐ Yes
Heart	☐ No	☐ Yes	Blood sugar/diabetes	☐ No	☐ Yes
Lungs	☐ No	☐ Yes	Seizures	☐ No	☐ Yes
Stomach/bowel	☐ No	☐ Yes	Depression	☐ No	☐ Yes
Kidneys	☐ No	☐ Yes	Thyroid	☐ No	☐ Yes
Joints/muscles	☐ No	☐ Yes	Blood pressure	☐ No	☐ Yes
Liver	☐ No	☐ Yes	Lymph nodes	☐ No	☐ Yes
Immune system	☐ No	☐ Yes	Reproductive organs	☐ No	☐ Yes
Hay fever/seasonal allergies	☐ No	☐ Yes			

Please explain any "yes" responses: _____

_____

_____

List any surgical procedures you have had in the last 6 months

_____

Do you have a history of skin cancer? ☐ No ☐ Yes

If so, what type? _____

Is there a family history of skin cancer? ☐ No ☐ Yes

If so, what type? _____

Do you have a history of a specific skin disease? ☐ No ☐ Yes

If so, what type? _____

Is there a family history of a specific skin disease? ☐ No ☐ Yes

If so, what type? _____

Do you form keloids (thick scars)? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes

(PAGE 1, TURN OVER)

PERMISSION FOR PHOTOGRAPHY

(Patient Sticker)

I consent to the taking of photographs of my skin lesion(s). I understand that these photographs will be a part of my medical record. They may also be used for educational purposes and professional publications. In such event, I will not be identified by name and I expect no compensation for these photographs.

I certify that I have read and fully understand the above consent.

PATIENT'S SIGNATURE **DATE**

I authorize SIU Dermatology to leave a message concerning laboratory results, biopsy results and prescription issues on my answering machine at the following phone number.

(Phone #)

PATIENT'S SIGNATURE **DATE**

Revised 10/28/11

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