QUARLES DERMATOLOGY

HISTORY AND PHYSICAL **Date:**________________________

Name:____ **Date of Birth:**____________________________

Address: ____**Phone: (h)** ______________(c)______________

Occupation/Employer:__________________________________**Insurance:** ________________________________

Referred By:____**Phone:**___________________________________

☐ **Male** ☐ **Female** ☐ **Ethnic** ______________________________________

CHIEF COMPLAINT:____

HISTORY OF PRESENT ILLNESS:____

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RX:____ **ALLERGIES:** ________________________________

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FAMILY HISTORY:

☐ Psoriasis ☐ Hay Fever ☐ Arthritis ____

☐ Skin Cancer ☐ Asthma ☐ Cancer ____

☐ Eczema ☐ Diabetes ☐ Hair Loss ____

PAST MEDICAL HISTORY:

☐ Recent Weight Loss/Gain ☐ Kidney Disease ____________________________________

☐ Asthma ☐ Hay Fever ☐ Arthritis ____________________________________

☐ Hives ☐ Eczema ☐ Migraine ☐ Headaches ____________________________________

☐ Psoriasis ☐ Herpes ☐ Seizures ____________________________________

☐ Keloids ☐ Neurol. Disease ____________________________________

☐ Skin Cancer ☐ Lupus ☐ Anemia ____________________________________

☐ Hair Loss ☐ Bleeding Diatheses ____________________________________

☐ Progressive ☐ Recent ☐ Cancer *type:* ____________ ____________________________________

☐ Aids Risk ☐ X-ray Therapy ____________________________________

☐ Diabetes ☐ Thyroid ☐ Previous Surgery ____________________________________

☐ Coronary Heart Disease ____________________________________

☐ Hypertension **FEMALES – PREGNANT** ____________________________________

☐ Lung Disease ☐ Menst. Irregular ____________________________________

☐ Hepatitis ☐ Birth Control ____________________________________

HABITS:

☐ Cigarettes - packs per day __________ ☐ Alcohol – oz. per week __________ ☐ Street Drugs ___________

☐ Coffee/Tea - cups per day __________ ☐ Regular Exercise _______________