REVIEW OF SYSTEMS

(MA initials: ____)

NAME: ______________________________________DATE OF BIRTH ___________________TODAY'S DATE ______________

REASON FOR VISIT: ____

PRIMARY CARE DOCTOR: ____________________________________

PREFERRED PHARMACY: _____________________________________

DRUG ALLERGIES: (list drug(s) and reaction (hives, rash, itching, shortness of breath…) ○ See List ○ None

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____

____

Do you have allergies to the following?
○ Latex – Yes / No ○ Bacitracin – Yes / No
○ Adhesive (Band-Aid) – Yes / No

MEDICATIONS / VITAMINS / SUPPLEMENTS:
○ See List ○ None

Drug Name	Dose	How often

VACCINATIONS:
Flu: Yes / No Date: ____________________
Pneumonia: Yes / No Date: ____________________
Covid: Yes / No Moderna / Pfizer / J & J
1st dose: Date: ____________________
2nd dose: Date: ____________________
Booster: Date: ____________________

COVID/TRAVEL HISTORY:

*Have you recently traveled abroad? **Yes / No**

*Have you been to an area known to be high risk for COVID-19? **Yes/No**

*In the 14 days before symptom onset, have you had close contact with a laboratory-confirmed COVID-19 while that case was ill? **Yes/No**

*In the 14 days before symptom onset, have you had close contact with a person who is under investigation for COVID-19 while that person was ill? **Yes/No**

SKIN DISEASE: Have you had any of the following skin conditions.
○ None
○ Acne ○ Eczema ○ Moles ○ Psoriasis ○ Flaky/itchy scalp
○ Precancerous Lesions ○ Skin Cancer: Type: _______________

CURRENT HEALTH PROBLEM(S)

____

____

PAST SURGERY: Please list any surgery you had in the past 3 years.
○ None

____

____

FAMILY HISTORY:
○ None ○ Asthma (Mother/Father/Siblings/others :_____________)
○ Diabetes (Mother/Father/Siblings/others :_____________)
○ Skin Cancer (Mother/Father/Siblings/others :_____________)
(Circle all that applies: Melanoma/Basal Cell/Squamous Cell)

SOCIAL HISTORY: (circle one)
Alcohol: Yes / No / Never (Occasionally/Moderate/Heavy)
Smoking: Yes / No / Never / Former Quit: Year ________
(Current day smoker/Current some day smoker)
Pregnant: Yes / No - Nursing (breast feeding): Yes / No

Do you have any of the following?
○ Power of Attorney (Surrogate decision maker)
Name: _________________________ Relation: ________________
Phone #: ________________________
○ Living Will / Advanced Directive

PAST MEDICAL HISTORY:

	YES	NO
Asthma		
Arthritis		
Bleed Easily		
Cataract		
COPD (Chronic Obstruction Pulmonary Disease)		
Diabetes		
Glaucoma		
Heart Attack		
Heart Failure		
High Blood Pressure		
Kidney Disease		
Liver Disease		
MRSA Infection		
Melanoma / Skin Cancer		
Pacemaker		
Pneumonia		
Stomach Ulcer		
Thyroid Problem – Hypothyroidism Hyperthyroidism		
Tuberculosis		

REVIEW OF SYSTEMS:

	YES	NO
Anxiety		
Chest pain		
Depression		
Easy Bruising		
Hayfever		
Headache		
Joint ache		
Muscle weakness		
Problem w/ bleeding		
Problem w/ healing		
Problem w/ scarring		
Shortness of Breath		
Weight loss (>10 lbs.)		