

# SODERSTROM SKIN INSTITUTE & PEORIA AMBULATORY SURGERY CENTER MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Reason for today's visit: (chief complaint) \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Allergies to drugs: \_\_\_\_\_ Other allergies: \_\_\_\_\_

Current Medications:	<u>Dosages &amp; Frequency:</u>	<u>Dosages &amp; Frequency:</u>
1) _____	_____ / _____	5) _____ / _____
2) _____	_____ / _____	6) _____ / _____
3) _____	_____ / _____	7) _____ / _____
4) _____	_____ / _____	8) _____ / _____

**Current or past problems with:**

Constitutional

- Recent fevers / sweats
- Unexplained weight loss / gain
- Unexplained fatigue / weakness
- Other \_\_\_\_\_

Eyes

- Contacts / glasses
- Cataracts
- Glaucoma
- Other \_\_\_\_\_

Ears / Nose / Throat / Mouth

- Difficulty hearing
- Hayfever, Congestion
- Trouble Swallowing
- Other \_\_\_\_\_

Lung / Respiratory

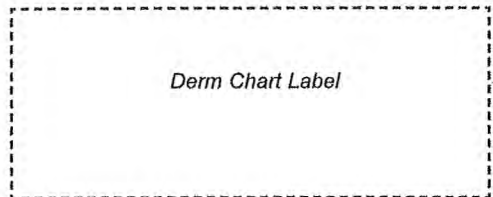
- Asthma
- Emphysema/COPD
- Short of breath with exertion
- Sleep Apnea
- Other \_\_\_\_\_

Stomach / Bowel / Gastrointestinal

- Heartburn / reflux
- Nausea / vomiting / diarrhea
- Pain in abdomen
- Other \_\_\_\_\_

Kidneys/ Genitourinary

- Kidney disease
- Dialysis, days: \_\_\_\_\_
- Other \_\_\_\_\_



Blood / Lymphatic

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <b>Y</b>                 | <b>N</b>                 | Easy bruising / bleeding <input type="checkbox"/> <input type="checkbox"/>             |
| <input type="checkbox"/> | <input type="checkbox"/> | Thrombophlebitis / blood clots <input type="checkbox"/> <input type="checkbox"/>       |
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin How long _____ <input type="checkbox"/> <input type="checkbox"/>               |
| <input type="checkbox"/> | <input type="checkbox"/> | Date of last dose _____ <input type="checkbox"/> <input type="checkbox"/>              |
| <input type="checkbox"/> | <input type="checkbox"/> | Nonsteroidal anti-inflammatory drugs <input type="checkbox"/> <input type="checkbox"/> |
|                          |                          | (ex. Bayer, Bufferin, Ibuprofen, Advil, Motrin, Naproxen, Aleve)                       |
| <input type="checkbox"/> | <input type="checkbox"/> | How long _____ <input type="checkbox"/> <input type="checkbox"/>                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Date of last dose _____ <input type="checkbox"/> <input type="checkbox"/>              |
| <input type="checkbox"/> | <input type="checkbox"/> | Coumadin How long _____ <input type="checkbox"/> <input type="checkbox"/>              |
| <input type="checkbox"/> | <input type="checkbox"/> | Date of last dose _____ <input type="checkbox"/> <input type="checkbox"/>              |
| <input type="checkbox"/> | <input type="checkbox"/> | Plavix How long _____ <input type="checkbox"/> <input type="checkbox"/>                |
| <input type="checkbox"/> | <input type="checkbox"/> | Date of last dose _____ <input type="checkbox"/> <input type="checkbox"/>              |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ <input type="checkbox"/> <input type="checkbox"/>                          |

Musculoskeletal

- Muscle / joint pain
- Arthritis
- Joint implants  Hip  Knee
- Other \_\_\_\_\_
- Routinely takes antibiotics prior to
- procedures. If yes, name of antibiotic and
- dosage: \_\_\_\_\_
- Other \_\_\_\_\_

Skin

- Rash / skin eruption
- New or change in mole
- History of thickened or unusual scars
- after surgery
- History of skin cancer
- Location \_\_\_\_\_
- History of radiation treatment
- Location \_\_\_\_\_
- # of treatments \_\_\_\_\_
- History of cold sores
- History of tanning/tanning beds
- Use sunscreen daily
- Other \_\_\_\_\_

Neurological

- Headaches
- Memory Loss
- Fainting

**Y N** Neurological (cont.)

- Seizures
- Stroke
- Dementia
- Other \_\_\_\_\_

Psychiatric

- Anxiety / stress
- Depression
- Other \_\_\_\_\_

Thyroid / Endocrine

- Cold / heat intolerance
- Increase thirst / appetite
- Diabetes mellitus
- Hyper / Hypo thyroid
- Other \_\_\_\_\_

Heart / Cardiovascular

- High blood pressure
- Controlled  Uncontrolled
- Low blood pressure
- Controlled  Uncontrolled
- High cholesterol
- Heart Attack
- Palpitations
- Murmur
- Valve Replacement
- Pacemaker
- Defibrillator
- Carotid Stenosis
- Aneurysm
- Other \_\_\_\_\_

Infectious Diseases

- Hepatitis B
- Hepatitis C
- HIV
- Other \_\_\_\_\_

Cancer (other than skin)

- If Yes - Specify \_\_\_\_\_

Females

- Pregnant # of weeks \_\_\_\_\_
- Planning on becoming pregnant

