

Ithaca Dermatology
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Patient Name: _____ Date: _____

Age: _____ Current Medical Problems:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Allergies:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Current Medications:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 8. _____ | 8. _____ |

Current or past problems with: (Review of systems)

	Yes	No	(if yes, explain)
General Health	_____	_____	_____
Eyes	_____	_____	_____
Ears/Nose/Throat/Mouth	_____	_____	_____
Heart	_____	_____	_____
Lungs	_____	_____	_____
Stomach/bowel	_____	_____	_____
Kidneys	_____	_____	_____
Arthritis/muscles/joints	_____	_____	_____
Skin	_____	_____	_____
Headaches/seizures	_____	_____	_____
Psychological disorder	_____	_____	_____
Thyroid/diabetes	_____	_____	_____
Allergic/immunologic	_____	_____	_____

Females: Are you pregnant? Y N Are you planning to become pregnant? Y N

Check the following medical conditions that have occurred in your family:

Disease:	Mother	Father	
Allergies	_____	_____	
Arthritis	_____	_____	
Asthma	_____	_____	
Cancer	_____	_____	
Diabetes	_____	_____	
Eczema	_____	_____	
Hay fever	_____	_____	
Heart Disease	_____	_____	
High Blood Pressure	_____	_____	
Lung Disease	_____	_____	
Malignant Melanoma	_____	_____	Occupation: _____
Psoriasis	_____	_____	Hobbies/Leisure Activities: _____
Skin Cancer	_____	_____	_____
Tuberculosis	_____	_____	_____