

DERMATOLOGY

HISTORY

CHIEF COMPLAINT

HISTORY OF
PRESENT ILLNESS

MEDICATIONS (List Milligrams)

ALLERGIES

MEDICAL HISTORY Check box if you have or have had any of the following symptoms or diseases.

- | | | | |
|--|---|------------------------------------|--|
| <input type="checkbox"/> HEARING PROBLEMS | <input type="checkbox"/> CHLAMYDIA | <input type="checkbox"/> GONORRHEA | SKIN PROBLEMS |
| <input type="checkbox"/> GLAUCOMA <input type="checkbox"/> CATARACTS | <input type="checkbox"/> RECENT WEIGHT LOSS | | <input type="checkbox"/> ECZEMA <input type="checkbox"/> PSORIASIS <input type="checkbox"/> RASH |
| <input type="checkbox"/> NOSEBLEEDS <input type="checkbox"/> SINUS TROUBLE | <input type="checkbox"/> ANEMIA <input type="checkbox"/> BRUISE EASILY | | <input type="checkbox"/> ABNORMAL <input type="checkbox"/> MOLES <input type="checkbox"/> HIVES |
| <input type="checkbox"/> HOARSENESS <input type="checkbox"/> HAY FEVER | <input type="checkbox"/> CANCER | | <input type="checkbox"/> FREQUENT SUN EXPOSURES |
| <input type="checkbox"/> ASTHMA <input type="checkbox"/> HYPERTENSION | <input type="checkbox"/> DIABETES <input type="checkbox"/> THYROID DISEASE | | <input type="checkbox"/> EXCESSIVE SCARRING |
| <input type="checkbox"/> CORONARY HEART DISEASE | <input type="checkbox"/> SEIZURES <input type="checkbox"/> STROKE | | <input type="checkbox"/> SKIN CANCER |
| <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> MIGRAINE HEADACHES | | <input type="checkbox"/> RECENT OR PROGRESSIVE HAIR LOSS |
| <input type="checkbox"/> PALPITATIONS <input type="checkbox"/> IRREG. PULSE | <input type="checkbox"/> ARTHRITIS <input type="checkbox"/> GOUT | | PREGNANT - YES <input type="checkbox"/> NO <input type="checkbox"/> |
| <input type="checkbox"/> VARICOSE VEINS <input type="checkbox"/> PHLEBITIS | <input type="checkbox"/> MENTAL ILLNESS <input type="checkbox"/> DEPRESSION | | |
| <input type="checkbox"/> DIFFICULT/SWALLOWING <input type="checkbox"/> HEARTBURN | <input type="checkbox"/> TUBERCULOSIS | | |
| <input type="checkbox"/> PEPTIC ULCER DISEASE <input type="checkbox"/> COLITIS | <input type="checkbox"/> ALLERGIES (NONDRUG) | | |
| <input type="checkbox"/> JAUNDICE <input type="checkbox"/> HEPATITIS | ALCOHOL - OZ/WK _____ | | |
| <input type="checkbox"/> KIDNEY STONES <input type="checkbox"/> PROSTATE PROB | SMOKING - CIG/DAY _____ # YEARS _____ | | |
| <input type="checkbox"/> VENEREAL DISEASE <input type="checkbox"/> HERPES | COFFEE/TEA-CUPS/DAY _____ | | |

FAMILY HISTORY

THE SKIN INSTITUTE
JOSEPH R. TERRACINA, M.D., P.A.
2525 Hwy. 1 South, Suite A
GREENVILLE, MISS. 38701