SUSANNE L. GEE, M.D., M.S.

Dermatology Cosmetic Surgery

Patient name _____ Age _____ Date _____

Allergies:
Current medications:

Reason for today's visit: (chief complaint)

_____

_____

_____

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	☐	☐	_____
Blood/bleeding disorder	☐	☐	_____
Allergic/immunologic	☐	☐	_____

Females: are you pregnant? __yes __no planning to become pregnant? __yes __no

Family History: (Past family & social history)

Mother: living/deceased_____ age____ Father: living/deceased_____ age____ No of children____ age(s)_____

Check following medical conditions that have occurred in your family:

Disease	Mother	Father	Blood Relative
Allergies	☐	☐	☐
Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Eczema	☐	☐	☐
Hayfever	☐	☐	☐
Heart disease	☐	☐	☐
High blood pressure	☐	☐	☐
Lung disease	☐	☐	☐
Malignant Melanoma	☐	☐	☐
Psoriasis	☐	☐	☐
Skin cancer	☐	☐	☐
Tuberculosis	☐	☐	☐

Social History:

Do you live alone? __no __yes
Do you drink alcohol? __no __yes-frequency_____

Do you smoke? __no __yes-frequency_____
Do you use recreational drugs? __no __yes-frequency____

Occupation_____

Hobbies/leisure activities_____

*Reviewed*_____ Date_____ Update _____