THE DERMATOLOGY CLINIC
Vitaly Terushkin, MD

Name vvvv_____ DOB _____Age ____ Sex ☐ M ☐ F Today's Date_____
Referred by: ☐ Self or ☐ Dr._____
Reason for visit?_____

History of today's problem only: HPI
Skin areas involved_____LOCATION
How long have you had the problem?_____ DURATION
Was a biopsy done? ☐ No ☐ Yes CONTEXT
Was there any treatment? ☐ No ☐ Yes When?_____Type? ☐ Mohs Other_____
Check all that apply to today's problem:

Associated Symptoms	Quality A change in:	Severity	Modifying factors A history of:
☐ Bleeding	☐ size	☐ no symptoms	☐ x-ray treatments (not routine or dental x-rays)
☐ Tingling	☐ color	☐ occasional symptoms	☐ UV light treatments
☐ Pain	☐ elevation	☐ constant symptoms	☐ arsenic exposure/treatments
☐ Ulceration	☐ hardness	☐ none	☐ immunosuppression
☐ Itching	☐ other _____		☐ other _____
☐ Infection	☐ none		☐ none
☐ other _____			
☐ none			

Medications Do you take any of the following medications? (check all that apply)
☐ Aspirin ☐ Plavix ☐ Gingko ☐ St. John's Wort
☐ Coumadin ☐ Vitamin E ☐ Ginseng ☐ Pain mediations: (list)_____
Please list all other current medications (including pain medications, vitamins, and non-prescription):_____
_____

Allergies Do you have any allergies? ☐ No ☐ Yes/please list medication and type of allergy:_____

Past medical and surgical history
Have you ever had skin cancer? ☐ No ☐ Yes/please list date, type and locations: _____
Have you ever had plastic surgery ☐ No ☐ Yes/please list date, type: _____
Do you have a pacemaker or defibrillator? ☐ No ☐ Yes/list:_____
Do you have any artificial joints ☐ No ☐ Yes/please list type and year of surgery _____
Do you have replaced heart valves? ☐ No ☐ Yes/please list type and year of surgery _____
Do you have any unrepaired congenital heart valve disease: ☐ No ☐ Yes/describe _____
Do you need to take antibiotics before a routine dental cleaning? ☐ No ☐ Yes/Why? _____
Other major illnesses or hospitalizations? None ☐ Yes/list: _____
Organ transplant recipient: ☐No ☐Yes/type: (if heart, any heart valve abnormalities):_____

Family History Please check if anyone of your family has been diagnosed with the following skin cancers:
☐ None ☐ Squamous cell carcinoma ☐ Basal Cell Carcinoma ☐ Melanoma ☐ Other _____
List relation and diagnoses _____

Social History Occupation (current or former):_____ Marital Status: ☐ S ☐ M ☐ D ☐ W
Do you wear? ☐ Dentures ☐ Glasses ☐ Contact Lenses
Smoking? ☐ Current ☐ Former Packs per day_____
Alcohol use: (beer, wine, or other alcoholic beverages) ☐ No ☐ Yes
If yes, how many times in the past year have you had: Men 5 or more drinks in a day ___ Women: 4 or more drinks in a day__
Alcohol and/or drug problems/addictions ☐No ☐Yes/describe:_____

Please continue to the reverse side of this page

System Review (Check all that apply regarding your health and add any other important problems)

Skin
- ☐ normal
- ☐ abnormal scarring
- ☐ poor healing
- ☐ other_____

Constitutional symptoms
- ☐ none
- ☐ weight loss
- ☐ fever
- ☐ other_____

Eyes/ears/nose throat
- ☐ normal
- ☐ glaucoma
- ☐ hearing aids
- ☐ other_____

Muscoloskeletal
- ☐ normal
- ☐ arthritis
- ☐ artificial joints
- ☐ other_____

Cardiovascular
- ☐ normal
- ☐ hypertension
- ☐ Infectious endocarditis
- ☐ heart attack
- ☐ other_____

Hematologic/lymphatic
- ☐ normal
- ☐ blood transfusions
- ☐ bleeding problems
- ☐ enlarged lymph nodes
- ☐ other_____

Intestinal
- ☐ normal
- ☐ stomach ulcer
- ☐ colon cancer
- ☐ colitis
- ☐ other_____

Infectious
- ☐ normal
- ☐ hepatitis (type_____)
- ☐ hiv/aids
- ☐ tuberculosis
- ☐ other_____

Neurological
- ☐ normal
- ☐ stroke
- ☐ seizures
- ☐ other_____

Respiratory
- ☐ normal
- ☐ asthma
- ☐ emphysema
- ☐ other_____

Urinary
- ☐ normal
- ☐ bladder cancer
- ☐ kidney cancer
- ☐ other_____

Psychiatric
- ☐ normal
- ☐ depression
- ☐ anxiety
- ☐ other_____

Endocrine
- ☐ normal
- ☐ diabetes
- ☐ thyroid disease
- ☐ other_____

Any other important problems_____

Signature of patient _____ Date_____

Reviewed by _____

DO NOT WRITE BELOW THIS LINE: **********FOR OFFICE USE ONLY ********