GRANGER MEDICAL CLINIC | *Dermatology*

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Patient Name: _____Date of Birth: _____Today's Date _____

What are you being seen for today:
1_____
2_____
3_____
4_____

Medications Currently Taking (If numerous, please provide us with a copy of your list):
_____

Drug allergies and reaction: _____
_____

Do you use tobacco: □ No □ Yes If yes, how much/often_____

Any new health issues BESIDES SKIN since your last visit and if so what?_____

_____

Have you ever had skin cancer? YES NO

Review of Systems

Do you currently have any problems in any of the following areas? (Please circle)

How are you feeling today?	Feeling well Feeling fair Feeling poorly
Constitutional	Fever Chills Night Sweats Fatigue N/A
Head	Headaches Dizziness N/A
Lumps under the skin (nodes)	Neck armpits groin N/A
Eyes	Grittiness Dry N/A
Lungs	Cough N/A
Digestive	Nausea N/A
Bleeding problems	Bleed easily N/A
Musculoskeletal	Joint pain/swelling N/A
Psychological	Anxiety Depression N/A
ANY OTHER SKIN PROBLEMS: IF YES PLEASE LIST:	YES NO

Established Patient Form

Office Use Only

HPI	Exam	Diagnosis	Treatment
Location	scalp		
	face		
Duration	eyelids		
	lips		
Symptoms: pain, itching, burning, tenderness	neck		
	chest		
Quality: bleeding, scaly, red, rough	back		
	abdomen		
Modifying factors	RUE		
	LUE		
	RLE		
	LLE		
	LAD		
	Genitals		

OTHER SKIN PROBLEMS: NO YES_____