Alabama Dermatology Associates
Medical, Surgical and Cosmetic Skin Care Specialists

REVIEW OF SYSTEMS

Date: _____

Do you now or have you recently had any of the following?

Yes	No	
☐	☐	*Problems with healing*
☐	☐	*Problems with scarring (hypertrophic or keloid)*
☐	☐	*Problems with bleeding or blood clots*
☐	☐	*Migraines*
☐	☐	*Anxiety*
☐	☐	*Depression*
☐	☐	*Dialysis or kidney disease*
☐	☐	Bloody urine
☐	☐	Rash
☐	☐	Hearing loss
☐	☐	Sore throat
☐	☐	Abdominal pain
☐	☐	Bloody stool
☐	☐	GI upset with antibiotics
☐	☐	Blurry vision
☐	☐	Chest pain
☐	☐	Cough
☐	☐	Shortness of breath
☐	☐	Wheezing
☐	☐	Fever or chills
☐	☐	Night sweats
☐	☐	Unintentional weight loss
☐	☐	Headaches
☐	☐	Seizures
☐	☐	Allergy to topical antibiotic ointments
☐	☐	Immunosuppression
☐	☐	Hay fever
☐	☐	Joint aches/arthritis
☐	☐	Muscle weakness
☐	☐	Neck stiffness
☐	☐	Thyroid problems
☐	☐	*New or changing mole*
☐	☐	*Pacemaker*
☐	☐	*Defibrillator*
☐	☐	*Artificial heart valve*
☐	☐	*Rapid heart beat with epinephrine*
☐	☐	*Pregnancy, planning a pregnancy or breastfeeding*
☐	☐	*Diabetes or excessive urination, thirst, or hunger*
☐	☐	*Yeast infections with antibiotics*
☐	☐	*Artificial joint(s)*
☐	☐	*Premedication with antibiotics prior to procedures*
☐	☐	*Allergy to adhesive*
☐	☐	*Allergy to lidocaine*
☐	☐	*Blood thinners*