



Christina Hardaway, M.D.

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DOB: Name: Age: Date: History of Present Illness -Referred By: Primary Care Physician: Preferred Pharmacy: Reason for Visit: How long have you had this issue? On what area of your body? Check the appropriate symptoms: Y Itching Y Painful Y Bleeding Y Burning Y Growing Y Comes and Goes Y Darkening List the Medications you have used to treat this skin problem What skin care products do you use? Social History -MY N Tobacco use: Do you use sun protection: (clothing, hats, sunscreen) Y N Y # ___ drinks per day Do you drink alcohol? Y N Use of tanning lights Y N Do you have a history of Y N How often do you used a tanning bed or lights? Y N blistering sunburns Extensive Sun Exposure Y N Exposure to radiation (other Y N than x-rays) Occupation: Where did you grow up PAST MEDICAL HISTORY (check positive answers LATEX ALLERGY MUSCULOSKETETAL Y Allergy to latex Y GLAUCOMA Y OSTEOARTHRITIS RESPIRATORY -Y RHEUMATOID ARTHRITIS SKIN -Y HAY FEVER Y OSTEOPOROSIS Y Skin Cancer: What type, where on your body Y ALLERGIES Y Presence Of Artificial Hip Joint when? TY ASTHMA Y BASAL CELL Y COPD Y Presence Of Artificial Knee Joint Y CARCINOMA SQUAMOUS CELL Y Presence Of Artificial Shoulder Joint Y MELANOMA HEMATOLOGIC -Y BLEEDING DISORDER-Excessive bleeding Y ACTINIC KERATOSIS during surgery. NEUROLOGIC -Y ATYPICAL MOLE Y MISCARRIAGES: Y STROKE Y ECZEMA Y PARALYSIS Y PSORIASIS ENDOCRINE -Y SCAR KELOID Y THYROID DISORDERS Y EPILEPSY AND RECURRENT SEIZURES Y HERPES SIMPLEX Y DIABETES MELLITUS Y MULTIPLE SCLEROSIS Y ACNE Y OVARIAN CYST Y MIGRAINE HEADACHE Y ROSACEA CANCER --IMMUNE/INFECTIOUS GASTROINTESTINAL Y Cancer (other than Skin) Y HEPATITIS Y LIVER DISEASE Y HIV INFECTION Y IRRITABLE BOWEL SYNDROME CARDIAC -Y AUTOIMMUNE DISEASE Y CROHN'S DISEASE Y BENIGN HYPERTENSION Y TUBERCULOSIS Y REFLUX- HEARTBURN Y HYPERLIPIDEMIA Y LEUKEMIA Y ULCER Y HEART ATTACK Y DRUGS USED (PREDNISONE, CHEMOTHERAPY, OTHER) Y RENAL DISEASE Y BYPASS SURGERY Y CARDIAC MURMUR PSYCHIATRIC -Y VALVULAR HEART DISEASE Y No significant medical history Y DEPRESSION Y HEART FAILURE Y Other: Y ANXIFTY Y Cardiac Devices Pacemaker Present TY BIPOLAR I DISORDER Y Cardiac Defibrillator TY OTHER





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Name: DOB: Date:

Review of Systems check problems that are present today

Skin/Nails Y N New or changing moles	Gynecological Y N Menses abnormal	Genitourinary Y N Blood in urine
Y N Localized skin discoloration Y N Acne	Y N Menarche	Y N Pain during urination
Y N Skin: a rash	Y N Pregnancy	Y N Urinary frequency
Y N Superficial skin pain burning	Y Patient is breastfeeding.	Y N Penile discharge
Y N Allergic reaction	Y Patient is NOT breastfeeding.	Y N Vaginal discharge
Y N Telangectasias	Y N History of miscarriages	Y N Genital lesion
Y N Skin lesions	Y N Menopause has occurred	
Y N Skin lesion: bleeds		
Y N Skin lesion: Sore		
Y N Itching (pruritus) Y N Skin Swelling		
Y N Dry Skin		
Y N Skin/nail infection		
Y N Symptoms of Nail/Skin Thickening.		
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Constitutional —	Endocrine —	Pagaignton
Y N Feeling fine	Y N Intolerance to heat	Respiratory N Shortness of breath
Y N Recent weight loss (lbs)	Y N Intolerance to cold	Y N Wheezing
Y N Recent weight gain (lbs)	∇ N Excessive thirst / fluid intake N Deepening of voice	Y N Cough
Y N Fever	Y N Changed sexual interest (libido)	Hematologic/ Lymphatic —
	Y N Loss of hair from head or body	Y N clotting problems
Psychiatric—	Y N Excessive facial/body hair	Y N Easy bleeding
Y N Depression		Y N Swollen lymph nodes
Y N Anxiety	Ears, Nose, Throat	Y N Limb swelling
Eyes		
Y N loss of part of field of vision Y N White / light spots in field of vision		Musculoskeletal N IN Joint pain, localized
Y N eyelid skin lesion	Y N Skin lesion on the lip	Y N Joint swelling, localized
Y N Eye sores	Y N Lesions in the mouth	Y N Muscle aches
Y N Eye imitation	Y N Lesions on the tongue	Y N Muscle weakness
(Neurologic) Continu
Y N Tingling	- Gastrointestinal -	Cardiac
Y N Headache	Y N Abdominal pain	☐ Y ☐ N Palpitations
Y N Numbness	Y N Diamhea	
Immunosuppression —	Y N Nausea	
Y N Immunosuppression drugs, Leukemia, Hiv or Other	Y N Vomiting	
Leukeilla, niv or Other	Y N constipation	J

List any other symptoms not listed above: ______





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FAMILY HISTORY

Indicate family relationship: Mother, Father, Brother or Sister

Family History; Indicate Mother, Father, Brothe	r, Sister ————		
Y SKIN CANCER:	Y BASAL CELL	Y SQUAMOUS CELL	Y MELANOMA
Y OVARIAN CYST	Y ECZEMA	Y ASTHMA	Y HAY FEVER
Y INHERITED GENETIC	Y PSORIASIS	Y ROSACEA	Y ACNE
CONDITIONS	Y ARTHRITIS		

List all medication, with dose and frequency.

List all allergies and reactions.