TDC
THE DOCTORS CLINIC

Virginia Mason Franciscan Health™

A part of Franciscan Medical Group

Name: _____ **DOB:** _____ **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

Tobacco use: ☐ Y ☐ N

Do you drink alcohol? ☐ Y ☐ N #___ drinks per day

Do you have a history of ☐ Y ☐ N
blistering sunburns?

Extensive sun exposure ☐ Y ☐ N

Exposure to radiation ☐ Y ☐ N
(other than xrays)

Occupation: _____

Do you use sun protection (clothing, hats, sunscreen)? ☐ Y ☐ N

Use of tanning lights ☐ Y ☐ N

How often do you use a tanning bed or lights? _____

Where did you grow up? _____

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Past Medical History (check positive answers)

Skin

- ☐ Y Skin Cancer: What type, where on your body and when? _____
- ☐ Y Basal Cell
- ☐ Y Carcinoma Squamous Cell
- ☐ Y Melanoma
- ☐ Y Actinic Keratosis
- ☐ Y Aytypical Mole
- ☐ Y Eczema
- ☐ Y Psoriasis
- ☐ Y Scar Keloid
- ☐ Y Herpes Simplex
- ☐ Y Acne
- ☐ Y Rosacea

Cardiac

- ☐ Y Benign Hypertension
- ☐ Y Hyperlipidemia
- ☐ Y Heart Attack
- ☐ Y Bypass Surgery
- ☐ Y Cardiac Murmur
- ☐ Y Valvular Heart Disease
- ☐ Y Heart Failure
- ☐ Y Cardiac Devices Pacemaker Present
- ☐ Y Cardiac Defibrillator

Musculoskeletal

- ☐ Y Osteoarthritis
- ☐ Y Rheumatoid Arthritis
- ☐ Y Osteoporosis
- ☐ Y Presence of Artifical Hip Joint
- ☐ Y Presence of Artificial Knee Joint
- ☐ Y Presence of Artificial Shoulder Joint

Endocrine

- ☐ Y Thyroid Disorders
- ☐ Y Diabetes Mellitus
- ☐ Y Ovarian Cyst

Gastrointestinal

- ☐ Y Liver Disease
- ☐ Y Irritable Bowel Syndrome
- ☐ Y Chrohn's Disease
- ☐ Y Reflux - Heartburn
- ☐ Y Ulcer
- ☐ Y Renal Disease

Immune/Infectious

- ☐ Y Hepatitis
- ☐ Y HIV Infection
- ☐ Y Autoimmune Disease
- ☐ Y Tuberculosis
- ☐ Y Leukemia
- ☐ Y Drugs Used (Prednisone, Chemotherapy, Other)

Neurologic

- ☐ Y Stroke
- ☐ Y Paralysis
- ☐ Y Epilepsy and Recurrent Seizures
- ☐ Y Multiple Sclerosis
- ☐ Y Migraine Headache

Respiratory

- ☐ Y Hay Fever
- ☐ Y Allergies
- ☐ Y Asthma
- ☐ Y COPD

Psychiatric

- ☐ Y Depression
- ☐ Y Anxiety
- ☐ Y Bipolar I Disorder
- ☐ Y Other

Hematologic

- ☐ Y Bleeding Disorder - Excessive bleeding during surgery
- ☐ Y Miscarriages

Latex Allergy

- ☐ Y Allergy to Latex

Ocular

- ☐ Y Glaucoma

Cancer

- ☐ Y Cancer (other than skin)

☐ Y No significant medical history

☐ Y Other:

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Review of Systems (check problems that are present today)

Skin/Nails
- ☐ Y ☐ N New or changing moles
- ☐ Y ☐ N Localized skin discoloration
- ☐ Y ☐ N Acne
- ☐ Y ☐ N Skin: a rash
- ☐ Y ☐ N Superficial skin pain burning
- ☐ Y ☐ N Urticaria/Hives
- ☐ Y ☐ N Allergic reaction
- ☐ Y ☐ N Telangectasias
- ☐ Y ☐ N Skin lesions
- ☐ Y ☐ N Skin lesion: bleeds
- ☐ Y ☐ N Itching (pruritus)
- ☐ Y ☐ N Skin swelling
- ☐ Y ☐ N Dry skin
- ☐ Y ☐ N Skin/nail infection
- ☐ Y ☐ N Symptoms of Nail/Skin thickening

Constitutional
- ☐ Y ☐ N Feeling fine
- ☐ Y ☐ N Recent weight loss (____lbs)
- ☐ Y ☐ N Recent weight gain (____lbs)
- ☐ Y ☐ N Fever
- ☐ Y ☐ N Feeling tired

Endocrine
- ☐ Y ☐ N Intolerance to heat
- ☐ Y ☐ N Intolerance to cold
- ☐ Y ☐ N Excessive thirst/fluid intake
- ☐ Y ☐ N Deepening of voice
- ☐ Y ☐ N Changed sexual interest (libido)
- ☐ Y ☐ N Loss of hair from head or body
- ☐ Y ☐ N Excessive facial/body hair

Neurologic
- ☐ Y ☐ N Tingling
- ☐ Y ☐ N Headache
- ☐ Y ☐ N Numbness

Gynecological
- ☐ Y ☐ N Menses abnormal
- ☐ Y ☐ N Menarche
- ☐ Y ☐ N Planning pregnancy
- ☐ Y ☐ N Pregnancy
- ☐ Y ☐ N Patient is breastfeeding
- ☐ Y ☐ N History of miscarriages #
- ☐ Y ☐ N Menopause has occurred

Musculoskeletal
- ☐ Y ☐ N Joint pain, localized
- ☐ Y ☐ N Joint swelling, localized
- ☐ Y ☐ N Muscle aches
- ☐ Y ☐ N Muscle weakness

Psychiatric
- ☐ Y ☐ N Depression
- ☐ Y ☐ N Anxiety

Eyes
- ☐ Y ☐ N Loss of part of field of vision
- ☐ Y ☐ N White/light spots in field of vision
- ☐ Y ☐ N Eyelid skin lesion
- ☐ Y ☐ N Eye sores
- ☐ Y ☐ N Eye irritation

Ears, Nose, Throat
- ☐ Y ☐ N Skin lesion on ears
- ☐ Y ☐ N Skin lesion on nose
- ☐ Y ☐ N Skin lesion on lip
- ☐ Y ☐ N Lesions in the mouth
- ☐ Y ☐ N Lesions on the tongue
- ☐ Y ☐ N Stuffiness

Immunosuppression
- ☐ Y ☐ N Immunosuppression drugs, leukemia, HIV or other

Genitourinary
- ☐ Y ☐ N Blood in urine
- ☐ Y ☐ N Pain during urination
- ☐ Y ☐ N Urinary frequency
- ☐ Y ☐ N Penile discharge
- ☐ Y ☐ N Vaginal discharge
- ☐ Y ☐ N Genital lesion

Hematologic/Lymphatic
- ☐ Y ☐ N Clotting problems
- ☐ Y ☐ N Easy bleeding
- ☐ Y ☐ N Swollen lymph nodes
- ☐ Y ☐ N Limb swelling

Cardiac
- ☐ Y ☐ N Chest pain
- ☐ Y ☐ N Palpitations

Gastrointestinal
- ☐ Y ☐ N Abdominal pain
- ☐ Y ☐ N Diarrhea
- ☐ Y ☐ N Nausea
- ☐ Y ☐ N Vomiting
- ☐ Y ☐ N Constipation

Respiratory
- ☐ Y ☐ N Shortness of breath
- ☐ Y ☐ N Wheezing
- ☐ Y ☐ N Cough

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List any other symptoms not listed above:

Indicate family relationship: Mother, Father, Brother or Sister

Family History: Indicate Mother, Father, Brother or Sister

☐ Y Skin Cancer _____	☐ Y Basal Cell _____	☐ Y Squamous Cell _____	☐ Y Melanoma _____
☐ Y Ovarian Cyst _____	☐ Y Eczema _____	☐ Y Asthma _____	☐ Y Hay Fever _____
☐ Y Psoriasis _____	☐ Y Rosacea _____	☐ Y Acne _____	☐ Y Arthritis _____
☐ Y Inherited Genetic Conditions _____			

List all medications, with dose and frequency:

List all allergies and reactions:

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