



Patient Name _____

MRN# _____

Government Mandated "Meaningful Use" Information
Birth Date
Gender
Race
Ethnicity
Language
Smoking History (If Age 13 or Older)
<input type="checkbox"/> Current Every Day Smoker
<input type="checkbox"/> Current Some Day Smoker
<input type="checkbox"/> Former Smoker
<input type="checkbox"/> Non-Smoker

Medical Problems

Medications		
Name	Dose	Frequency

Surgeries	
Procedure	Date

Allergies (to Medication, Dyes, Latex, Etc.)	
Medication	Reaction

Family Medical Problems	
Relation	Health Problem

Constitutional		Cardiovascular		Neurological		Musculoskeletal		
No	Yes	Chills	No	Yes	Chest pain	No	Yes	Back pain
No	Yes	Fatigue	No	Yes	Claudication	No	Yes	Joint pain
No	Yes	Fever	No	Yes	Edema	No	Yes	Joint swelling
No	Yes	Malaise	No	Yes	Palpitations	No	Yes	Muscle weakness
No	Yes	Weight gain	No	Yes	Cold hands	No	Yes	Neck pain
No	Yes	Weight loss	No	Yes	Cold feet	No	Yes	Dropping objects
HEENT		Gastrointestinal		Psychiatric		Hematologic / Lymphatic		
No	Yes	Ear drainage	No	Yes	Abdominal pain	No	Yes	Easy bleeding
No	Yes	Ear pain	No	Yes	Constipation	No	Yes	Easy bruising
No	Yes	Eye discharge	No	Yes	Diarrhea	No	Yes	Swollen Lymph Nodes
No	Yes	Nasal Drainage	No	Yes	Loss of appetite	No	Yes	History blood clots
No	Yes	Visual Changes	No	Yes	Nausea	No	Yes	Healing problems
No	Yes	Dry eyes	No	Yes	Vomiting	No	Yes	Accutane use last 12 mo
Respiratory		Metabolic / Endocrine		Integumentary		Immunologic		
No	Yes	Chronic cough	No	Yes	Brittle nails	No	Yes	Environmental allergies
No	Yes	Cough	No	Yes	Cold intolerance	No	Yes	Food allergies
No	Yes	Known TB exposure	No	Yes	Hair changes	No	Yes	Seasonal allergies
No	Yes	Shortness of Breath	No	Yes	Heat intolerance	No	Yes	Breast Mass
No	Yes	Wheezing	No	Yes	Increased thirst	No	Yes	Breast Discharge
No	Yes	Blood in sputum	No	Yes	Increase appetite	No	Yes	Nursing
						Anesthesia		
						No	Yes	Malignant hyperthermia
						No	Yes	Anesthesia problems

WHAT IS THE CONDITION FOR WHICH YOU ARE YOU SEEING THE DOCTOR TODAY?

 I, the undersigned, affirm that the information I have given is correct to the best of my knowledge. I authorize treatment of the person named as "patient." I understand that Schaberg Dermatology will file with my primary insurance company for services rendered and authorize payment of medical insurance benefits directly to Schaberg Dermatology. I also authorize Schaberg Dermatology to obtain or release any information that is related to the treatment of the "patient." A photocopy of this authorization shall be considered as effective and valid as the original document.

 Signature

 Print Name

 Date