



Patient Name _____

MRN# _____

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