Commerce Institute of Skin

Annette C. LaCasse, D.O.

Medical History

Full Name:(Print) _____ **Date of Birth:** _____

Reason for today's visit (chief complaint): _____

_____

Current or past problems with (Review of systems)

	Yes	No	
General Health	___	___	_____
Eyes	___	___	_____
Ears/Nose/Throat/Mouth	___	___	_____
Heart	___	___	_____
Lungs	___	___	_____
Stomach/Bowel	___	___	_____
Kidney's	___	___	_____
Arthritis/Muscles/Joints	___	___	_____
Skin	___	___	_____
Headaches/Seizures	___	___	_____
Psychological Disorder	___	___	_____
Thyroid/Diabetes	___	___	_____
Blood/Bleeding Disorder	___	___	_____
Allergic/Immunologic	___	___	_____

Women:

Are you pregnant? Yes __ No __ Could you be pregnant? Yes___ No___ Planning to become pregnant? Yes __ No __

Abnormal periods? ____ Date of last period: _____ Excessive facial and/or body hair? _____

Family History: (Past family and social history)

Mother: ___ Living ___ Deceased ___ Age **Father**: ___ Living ___ Deceased ___ Age

Check the following medical conditions that have occurred in your **family**:

Disease	Mother	Father	Blood Relative
Allergies	___	___	___
Arthritis	___	___	___
Asthma	___	___	___
Cancer	___	___	___
Diabetes	___	___	___
Eczema	___	___	___
Hay fever	___	___	___
Heart Disease	___	___	___
High Blood Pressure	___	___	___
Lung Disease	___	___	___
Malignant Melanoma	___	___	___
Psoriasis	___	___	___
Skin Cancer	___	___	___
Tuberculosis	___	___	___

Any family history of skin cancer or other cancer? If yes please describe: _____

_____