Cayce
DERMATOLOGY CENTER

Village of Cherry Hill
2011 Corona Road ~ Suite 207 ~
Columbia, MO 65203
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www.columbiaderm.com

Your Name

Preferred Pharmacy: _____

Primary / Referring Doctor: _____

Any changes in your medications since your last visit? Yes / No

Have you ever received a pneumonia vaccination? Yes / No (Est. Date _____)

Have you received your flu vaccination this year? Yes / No
(If no, your reason: ☐Refusal ☐Allergy ☐Other Medical Reason?)

Any changes in your health since your last visit? Yes / No

Briefly, why are you being seen today?

Review of Systems

Please mark what you are experiencing today. If it does not apply to you, leave blank.

- ☐ Changing mole or suspicious growth
- ☐ Rash
- ☐ Itching
- ☐ Problems with healing
- ☐ Problems with scarring (hypertrophic/keloid)
- ☐ Dry or Irritated skin
- ☐ Allergy to adhesive
- ☐ Allergy to topical antibiotic ointments
- ☐ Problems with bleeding
- ☐ Taking blood thinners
- ☐ Seasonal allergies
- ☐ Dry eyes
- ☐ Blurry vison or vision loss
- ☐ Sore throat
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Unintentional weight loss
- ☐ Appetite loss
- ☐ Night sweats
- ☐ Chest pain
- ☐ Cough
- ☐ Abdominal pain
- ☐ Bloody stools
- ☐ Bloody urine
- ☐ Shortness of breath or wheezing
- ☐ Joint pain or swelling
- ☐ Muscle weakness
- ☐ Headaches
- ☐ Lightheadedness or dizziness
- ☐ Anxiety
- ☐ Depression
- ☐ Seizures
- ☐ Thyroid problems
- ☐ Yeast infections with antibiotics
- ☐ Irregular, painful, or excessively heavy periods
- ☐ Allergy to lidocaine or numbing shots
- ☐ Artificial joints and advised to take antibiotics before procedures
- ☐ Immunosuppression
- ☐ Pacemaker or defibrillator
- ☐ Rapid heartbeat when given epinephrine
- ☐ Pregnancy or planning pregnancy
- ☐ Other _____