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CHIEF COMPLAINT (WHY ARE YOU HERE?)

WHERE IS THE PROBLEM?

HOW LONG HAVE YOU HAD THE PROBLEM?

ASSOCIATED SIGNS/SYMPTOMS (ITCHING, BLEEDING, CHANGING, ETC.)

PAST TREATMENTS

CURRENT TREATMENTS (PROACTIV, NEUTROGENA, ETC)

ALLERGIES TO MEDICINES AND REACTIONS

ARE YOU INTERESTED IN THE FOLLOWING?

_____ BOTOX

_____ MICRODERMABRASION

_____ PEELS

_____ SKIN CARE

_____ COSMETICS

_____ FILLERS (RESTYLANE, JUVEDERM, COLLAGEN)

MEDICATIONS

(PRESCRIPTION, OVER THE COUNTER MEDS, HERBS AND VITAMINS)

COULD YOU BE PREGNANT? (TUBES TIED, HYSTERECTOMY)

PAST MEDICAL HISTORY (DIABETES, HEART DISEASE, ASTHMA, HIV, HEPATITIS, AIDS, SEXUALLY TRANSMITTED DISEASES)

PAST SURGICAL HISTORY (TONSILS, APPENDIX)

ALCOHOL USE

HOBBIES

MARITAL STATUS

SMOKING HISTORY

ULTRAVIOLET LIGHT EXPOSURE (USE SUNSCREEN, HISTORY OF TANNING BED USE, HISTORY OF BLISTERING SUNBURNS)

FAMILY HISTORY
(CANCER, SKIN CANCER, AUTOIMMUNE DISEASE)

REVIEW OF SYSTEMS (HOW ARE YOU FEELING NOW?)

Circle or mark the following:

Abdominal cramps or pain, angry feelings, blood clotting problems, burning skin, change in skin lesions, diarrhea, depression, dry skin, excessive scar tissue, fatigue, fever, headache insomnia, itching nausea, night sweats, non healing wounds, pigment change, recent weight change, unusual scar formation, vision changes

THANKS, AND REMEMBER YOUR PAPER WORK NEEDS TO BE AT THE OFFICE 5 DAYS BEFORE YOUR APPOINTMENT!!!!

Reviewed by: _____ Date: _____