

Name: \_\_\_\_\_

Primary reason for appointment: \_\_\_\_\_

Did another physician ask you to come today? If so whom? \_\_\_\_\_

Are you currently experiencing problems or have you had problems in the past with your:

- |                                                                                                                             |     |    |
|-----------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. General Well Being (fever, unintended weight loss, fatigue)?                                                             | YES | NO |
| 2. Eyes (pain, itching)?                                                                                                    | YES | NO |
| 3. Ears, Nose, Mouth or Throat (sinus trouble, ear infections)?                                                             | YES | NO |
| 4. Cardiovascular System (pacemaker, heart murmur, chest pain, high blood pressure)?                                        | YES | NO |
| 5. Respiratory System (asthma, shortness of breath, cough)?                                                                 | YES | NO |
| 6. Gastrointestinal System (nausea/vomiting, diarrhea, blood in stool, liver disease)?                                      | YES | NO |
| 7. Genitourinary System (kidney disease, HIV/AIDS, STD)?                                                                    | YES | NO |
| 8. Musculoskeletal System (arthritis, joint replacement)?                                                                   | YES | NO |
| 9. Neurologic System (seizures, stroke)?                                                                                    | YES | NO |
| 10. Psychiatric System (depression, anxiety, other mental illness)?                                                         | YES | NO |
| 11. Endocrine System (thyroid disease, diabetes, hair loss, irregular menses)?                                              | YES | NO |
| 12. Blood/Lymphatic System (anemia, blood clots)?                                                                           | YES | NO |
| 13. Allergic/Immunologic System (lupus, stiffness, recurrent infections)?                                                   | YES | NO |
| 14. Skin (rash, problems with adhesives, keloid scars, dry skin, itching, photosensitivity, easy bruising, skin fragility)? | YES | NO |

Do you have a history of cancer (including of the skin)? YES NO  
If so, what type? \_\_\_\_\_

Do you currently use or have you used a tanning bed? YES NO

Do you take antibiotics before going to the dentist? YES NO

Do you have a history of cold sores? YES NO

Have you had any changes in your general health or do you have anything about your medical history that you feel Dr. Friedrichs should know? \_\_\_\_\_

**Due to the increase in skin cancer and malignant melanoma, Dr. Friedrichs recommends a Full Body Skin Examination. Would you like to have your moles and skin screened for cancer?**

YES NO

A Full Body Exam may require scheduling additional time at another visit. If that is the case, please tell the receptionist when you check out that you would like to have a Full Body Exam at your next appointment.

Patient Signature: \_\_\_\_\_

Physician Initials: \_\_\_\_\_

Date: \_\_\_\_\_