



1120 BAYVIEW DRIVE
FORT LAUDERDALE

WILL RICHARDSON, MD PA
BOARD CERTIFIED
DERMATOLOGIST

PATIENT NAME _____

DATE _____

IT IS HELPFUL TO GATHER INFORMATION ABOUT YOUR MEDICAL HISTORY FOR THE PHYSICIAN TO USE IN YOUR EXAMINATION. PLEASE COMPLETE THIS FORM FOR THE PHYSICIAN'S REVIEW.

1. Constitutional: Fever, high blood pressure, weight loss, weakness, fatigued, night sweats, etc.

YES NO

2. Eyes: Vision, eye pain, etc.

YES NO

3. Ears, nose, mouth, throat: Hearing, dizziness, hoarseness, post-nasal drip, etc.

YES NO

4. Cardiovascular: Chest pain, palpitations, murmur, etc.

YES NO

5. Respiratory: Cough, shortness of breath, snoring, wheezing, etc.

YES NO

6. Gastrointestinal: Constipation, diarrhea, abdominal pain, heart burn, etc.

YES NO

7. Genitourinary: Urine frequency, blood in urine, burning during urination, irregular menstrual periods, discharge, etc.

YES NO

8. Musculoskeletal: Muscle pain, cramps, joint stiffness, etc.

YES NO

9. Integumentary (skin and/or breast): Pain, lump, discharge, skin rashes, etc.

YES NO

10. Neurological: Headaches, fainting, dizziness, etc.

YES NO

11. Psychiatric: Depression anxiety, memory loss, etc.

YES NO

12. Endocrine: Hot flashes, diabetic, heat/cold intolerance, etc.

YES NO

13. Hematologic/Lymphatic: Varicose veins, bruising, anemia, etc.

YES NO

14. Allergic/Immunologic: Hives, itching in the eyes/nose/throat/skin, reoccurring fever, etc.

YES NO

FAMILY HISTORY

1. Does your family have a history of Heart Disease (heart attack, heart failure)?

YES NO

2. Does your family have a history of strokes?

YES NO

3. Does your family have a history of high blood pressure?

YES NO

4. Does your family have a history of diabetes?

YES NO

SOCIAL HISTORY

1. What kind of work do you do?

2. Do you smoke?

YES NO

How many packs per day? _____

For how many years? _____

3. Do you drink alcohol?

YES NO

How many drinks?

_____ per day _____ per week _____ per month

PAST HISTORY

1. Do you have any allergies (food, drug, and/or environmental)?

YES NO If YES please list.

2. Have you had any operations, injuries/trauma, or past hospitalizations in the last 5 years?

YES NO

3. What was the approximate date of your last physical examination?

4. List all medications (drugs, pills) that you are currently taking (OTC and/or Rx):

Attach a separate sheet if necessary