ACNE

NAME:__________________ **AGE:_____** **HT:_____** **WT:_____**

WHO IS YOUR FAMILY PHYSICIAN? _____________________

CC: ACNE

PMH: ARE YOU ALLERGIC TO ANY MEDICATIONS OR LATEX ?___________

MEDICATIONS YOU TAKE:

SURGERY YOU HAVE HAD:

MEDICAL PROBLEMS YOU HAVE:

SOCIAL HISTORY

DO YOU SMOKE? Y/N
DO YOU DRINK ALCOHOL? Y/N

FEMALE PATIENTS

LAST MENSTRUAL PERIOD? ________

LAST MAMMOGRAM ? ________

ARE YOU BREAST FEEDING ? Y/N

ARE YOU PREGNANT? Y/N

FAMILY HISTORY

HAVE YOU OR A FAMILY MEMBER HAD A PROBLEM WITH GENERAL ANESTHESIA? Y/N

DOES ANYONE IN YOUR FAMILY HAVE SKIN CANCER/MELANOMA OR BREAST CANCER? Y/N

ROS:
WT LOSS, N/V, F/C
CHANGE IN VISION
SOB/DOE/CP
ABD PAIN /DIARRHEA
DYSURIA/HEMATURIA
SKIN RASH
DEPRESSION/
WEAKNESS
BACK PAIN/JOINT PAIN

PE: T P R BP
GEN: WD WN NAD
HEENT: NCAT EOMI
NECK: NT CV: SR PULM: CTA
ABD: SOFT NT ND EXT: NO CCE
NEURO: MOTOR/SENSORY WNL
LAN: AXILLA Y/N INGUINAL Y/N H/N Y/N

DERM:#1
#2
#3
#4
#5

A: ACNE
P: DUAC Q AM/PM
BENZAMYCIN Q AM/PM
BENZACLIN Q AM/PM
DIFFERIN Q AM/PM
TAZORAC Q AM/PM

DOXY 100 BID #60
MINOCYCLINE 50 BID #60
SKIN CARE INSTRUCTIONS

MARC S. SCHEINER, M.D. DATE_____________