ADVANCED DERMATOLOGY
of the Midlands

FOLLOW-UP OFFICE VISIT

Directions: Please fill in the blanks &check all that apply. Write" NA" in any sections that are "not applicable" to your visit.

Patient Name: _____ Date of Birth: _____

ARE YOU COMING TO SEE US PRIMARILY FOR A SKIN/MOLE CHECK? ☐ Yes ☐ No

We offer a complete skin check to all patients. For many, especially adults, this should be repeated once each year. Would you like a complete skin check today-this would require you to put on a gown? ☐ Yes ☐ No
Please note that if we will be examining areas you normally cover with makeup, the makeup should be left off or removed prior to the provider examining you.

WHAT IS/ARE THE REASON (S) FOR THIS VISIT? _____

WHERE IS/ARE THE PROBLEM(S) LOCATED? _____

IF THIS IS A FOLLOW-UP FOR A PROBLEM WE HAVE SEEN YOU FOR BEFORE, IS THE PROBLEM BETTER, WORSE, OR THE SAME? PLEASE GIVE DETAILS. _____

_____

HAVE YOU HAD ANY OF THESE OTHER PROBLEMS RECENTLY?

☐ Reduced appetite/energy	☐ New or changing moles	☐ Planning pregnancy, pregnant, or breastfeeding
☐ Headache	☐ Joint pain/back pain	☐ Changes in memory/concentration
☐ Allergies	☐ Cough	☐ Intolerance to hot/cold environments
☐ Sore throat	☐ Shortness of breath	☐ Excessive thirst or urination
☐ Chest pain	☐ Irregular heart beat	☐ Changes in mood or anxiety level
☐ Belly pain	☐ Diarrhea/constipation	☐ Burning with urination/blood in urine
☐ Blood in stools	☐ Nausea or vomiting	☐ Weight gain or loss (more than 10 pounds)
☐ Numbness or tingling	☐ Difficulty moving arms/legs	☐ Changes in vision/hearing/smell/taste

If you have had any of these problems recently, please give more details (when, where, how, etc)_____

_____

_____

Would you like to discuss cosmetic services for facial rejuvenation, reducing the appearance of fine lines and wrinkles and/or laser hair removal with your healthcare provider today? ☐ Yes ☐ No

Would you like to receive information on cosmetic services via email? ☐ Yes ☐ No

Email: _____