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ANNUAL HISTORY & PHYSICAL FORM

NAME: _____

REFERRING/PRIMARY CARE PROVIDER: _____

DRUG ALLERGIES: _____

MEDICATIONS: _____

PAST MEDICAL CONDITIONS: _____

PAST SURGERIES: _____

SOCIAL HISTORY: ALCOHOL Yes No If Yes, How often? _____

TOBACCO Never Smoker Former Smoker Current Smoker

PERSONAL/FAMILY HISTORY OF SKIN CANCERS: Basal Cell Carcinoma Self Family
 Squamos Cell Carcinoma Self Family
 Melanoma Self Family

PERSONAL/FAMILY HISTORY OF OTHER SKIN DISEASES: _____

PATIENT PHARMACY INFORMATION

NAME OF PHARMACY _____ PHONE _____

ADDRESS _____

Review of Systems – Please CIRCLE any problems you currently have.

- | | | | |
|--------------------------------|---------------------------|------------------------|----------------------------------|
| Abdominal pain | Blurry vision | Headaches | Problems with scarring |
| Anxiety | Changing mole | Immunosuppression | Seizures |
| Allergy to adhesive | Chest pain | Joint aches | Shortness of breath |
| Allergy to lidocaine | Cough | Muscle weakness | Sore throat |
| Allergy to topical antibiotics | Defibrillator | Pacemaker | Thyroid problems |
| Blood thinners | Depression | Problems with bleeding | Unintentional weight loss |
| Bloody stool | Fever or Chills | Problems with healing | Yeast infection with antibiotics |
| Bloody urine | GI upset with antibiotics | | |

OTHER: _____