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DERMATOLOGY
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HEALTH HISTORY

PATIENT'S NAME _____ DATE OF BIRTH_____

What are your skin concerns today? _____

Past Medical History: (check all that apply)

__Anxiety
__Arthritis
__Asthma
__Atrial fibrillation
__Bleeding tendency
__Blood clot
__Cancer (other than skin):
(type) _____
(type) _____
__Coronary artery disease
__Depression
__Diabetes
__Eye or vision problems
__Heart disease
__HIV / AIDS
__Hepatitis B
__Hepatitis C
__High blood pressure
__High cholesterol
__Keloids or abnormal healing
__Leg swelling or varicose veins
__Liver disease
__Lymphoma
__Radiation Treatment
__Stroke
__Thyroid disorder
__Other: _____

Past Surgeries: (check all that apply)

__Appendix removed
__Bladder removed
__Mastectomy
__Lumpectomy
__Breast biopsy
__Breast reduction
__Breast implants
__Colectomy: colon cancer resection
__Colectomy: Diverticulitis
__Colectomy: IBD
__Gallbladder Removed
__Coronary artery bypass
__Mechanical valve replacement
__Biological valve replacement
__Heart transplant
__Joint replacement, knee (R, L, Bilateral)
__Joint replacement hip (R, L, Bilateral)
__Joint replacement within last 2 years
__Knee biopsy
__Kidney removed
__Kidney stone removal
__Kidney transplant
__Ovaries removed: endometriosis
__Ovaries removed: cyst
__Ovaries removed: ovarian cancer
__Prostate removed: prostate cancer
__Prostate biopsy
__TURP (prostate removal)
__Spleen removed
__Testicles removed
__Hysterectomy: Fibroids
__Hysterectomy: uterine cancer

Skin Disease History: (check all that apply)

__Acne
__Actinic Keratoses
__Asthma
__Basal Cell Skin Cancer
__Blistering Sunburn
__Dry Skin
__ Eczema
__Flaking or Itchy Scalp
__ Hay Fever/ Allergies
__Melanoma
__Poison Oak
__Precancerous Moles
__Psoriasis
__Squamous Cell Skin Cancer
__Other :
_____
_____
_____
_____
_____
_____

Do you wear sunscreen? __No __Yes, SPF:_____

Do you use tanning beds? __Never __Occasionally use(d) tanning bed __Regularly use tanning beds

Do you have a family history of Melanoma? __No __Yes, relative: _____

Do you have a family history of other skin cancer? __ No __ Yes, relative:_____

Have you had your flu vaccine this year? __ No __ Yes, date:_____

If you are 65 or older have you ever had a pneumococcal vaccine? __ No __ Yes, date:_____

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Current Medications (if none, please write "none")

_____ _____
_____ _____
_____ _____

Allergies to medications: (or write "none" if no known drug allergies)

_____ _____
_____ _____

Do you smoke: __Currently smokes __Formerly smoked __Never smoked
Alcohol use: __None __Less than 1 drink per day __1 to 2 drinks per day __3 or more drinks per day
Are you currently pregnant, breastfeeding, or trying to conceive: _____
Where did you grow up? _____
Your occupation and place of work: _____

SYMPTOMS (please check all that apply to you):

__Fever or chills
__Malaise
__Unintentional weight loss
__Problems with bleeding
__Problems with healing
__Problems with scarring
__Hay fever
__Cough
__Chest plain
__Night sweats
__Thyroid problems
__Sore throat
__Shortness of breath
__Bloody stool
__Bloody urine
__Joint aches
__Muscle weakness
__Headaches
__Seizures
__Irregular menses

Do you have any of the following:

__ Pregnant, trying to conceive, breastfeeding
__Allergy to adhesive
__Allergy to lidocaine
__Allergy to topical antibiotics
__Artificial heart valve
__Artificial joint replacement
__Blood thinners
__Defibrillator
__ HIV or AIDS
__MRSA
__Pacemaker
__Require antibiotics prior to surgery
__Rapid heartbeat with epinephrine
__Immunosuppression

Preferred Pharmacy:_____
Name Location Phone

Cosmetic Interest: (check if you would like information about any)

__Age spot treatment
__Botox
__Latisse
__Sunscreen advice
__Wrinkle correction
__Skin care advice
__Retin A

SIGNATURE:_____ DATE:_____
PRINT NAME:_____