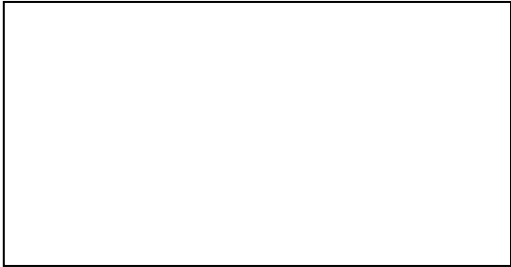


Dermatology Patient Health History



Please fill out as completely as possible and bring with you on the day of your appointment.

Reason For Visit: _____

Phone Numbers: Home (____) _____ Work (____) _____ Cell (____) _____

Primary Care Physician: _____ **Referring Physician:** _____

Medications: (Please include herbal supplements, vitamins, over-the-counter medications, and topical medications)

Allergies to medications: Yes No (Please Specify) _____

Do you have any of the following? (Please answer yes or no or family on each line-do not leave blank):

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Fevers/Chills	<input type="checkbox"/>	<input type="checkbox"/>	Joint Aches	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>	Leg Swelling (edema)	<input type="checkbox"/>	<input type="checkbox"/>
Stomach (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	Depression or Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Problems (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	Eye problems	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Past Medical History / Family History

	<u>Personal</u>		<u>Family</u>			<u>Personal</u>		<u>Family</u>	
	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>
Malignant Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Basal Cell Carcinoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squamous Cell Carcinoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Moles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver / Hepatitis Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal Allergies / Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypo / Hyper Thyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Prior Surgeries: None _____

If you are Female: Are You Pregnant? Yes No Trying to become pregnant? Yes No

Breastfeeding? Yes No

Do you drink Alcohol? Yes No # of drinks/week _____ **Do you Smoke?** Yes No How often? _____

Marital Status: Single Married Divorced Widowed **Occupation:** _____

Patient Signature _____ Date _____

Reviewed by (Physician): _____ Date _____