HEALTH HISTORY

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NAME _____ **REFERRED BY** _____

TODAY'S DATE_____ **OCCUPATION**_____

DATE OF BIRTH _____ **AGE** _____ **HEIGHT**_____ **WEIGHT**_____

REASON YOU ARE SEEING THE DOCTOR _____

SYMPTOMS Use **"C"** for current and **"P"** for previous and **"N/H"** for never had **CHECK ALL THAT APPLY**

GENERAL
__Depression
__Dizziness
__Fever
__Headaches
__Loss of weight
__Nervousness
__Sweats
__Fainting

MUSCLE/JOINT/BONE
__Joint Replacement
__Pain
__Surgery
__Weakness

GASTROINTESTINAL
__Appetite Change
__Bowel Changes
__Stomach Pain

CARDIOVASCULAR
__Chest Pain
__ High Blood Pressure
__Irregular Heartbeat
__Low Blood Pressure
__Pacemaker
__Poor Circulation
__Shortness of Breath
__Swelling of Ankles
__Trouble Clotting
__Varicose Veins

SKIN
__Bruise easily
__Change in Moles
__Cold Sores, fever
__Blisters
__Hives
__Infection
__Itching
__Rash
__Scars, Keloids
__Sore that won't heal
__Eczema
__Psoriasis
__Skin Cancer
__Basal Cell Carcinoma
__ Squamous Cell Carcinoma
__ Melanoma

GENITO-URINARY
__Painful Urination
__Menstrual Problems

EARS/NOSE/THROAT
__Hay Fever
__Nosebleeds
__Sinus Problems

BREAST PROBLEMS
__ Tender Breasts
__ Discharge from Nipples
__ Lumps or recent change in size

Please explain any positive response: _____

CONDITIONS **Use "C" for current and "P" for previous** **CHECK ALL THAT APPLY**

__AIDS
__Alcoholism
__Anemia
__Anorexia
__Arthritis
__Asthma
__Bleeding disorders
__Breast Lump
__Bulimia
__Cancer
__Chemical Dependency
__Chicken Pox
__Diabetes
__Emphysema
__Epilepsy
__Fibrocystic Disease
__Glaucoma
__Goiter
__Gout
__Hay Fever
__Heart Disease
__Heart Murmur
__Hepatitis
__Herpes
__High Cholesterol
__HIV Positive
__Hormone Problems
__Joint Replacement
__Kidney Disease
__Liver Disease
__Lung Disease
__Melanoma
__Migraine Headaches
__Mitral Valve Prolapse
__Moles Removed
__Mononucleosis
__Multiple Sclerosis
__Pacemaker
__Rheumatic Fever
__Stroke
__Thyroid Problems
__Tuberculosis
__Typhoid Fever
__Ulcers
__Other

Please explain: _____

MEDICATIONS: List those you are currently taking (List type, dosage and duration)_____

_____

DRUG ALLERGIES
__Food __Aspirin
__Anesthetics __Erythromycin
__Codeine __Sulfa
__Penicillin __Lidocaine
__Tetracycline __Other
__Novocaine List type of allergic reaction_____

NON-DRUG ALLERGIES
__Tape __Anesthetic
__Latex __Other _____

HORMONE REPLACEMENT/BIRTH CONTROL
Are you taking any kind of hormone replacement's_____
Are you taking any kind of birth control _____
If yes, please list_____

DIET MEDICATIONS
Currently taking or within this year any **diet or herbal medications**?___
If yes, please list_____ how long taking_____

Name of Pharmacy you usually use _____ **Pharmacy Phone Number** _____

LIST ALL HOSPITALIZATIONS, OPERATIONS (INCLUDING PLASTIC SURGERY) AND SERIOUS INJURIES:

Year	Hospitalization-Operation-Injury	Hospital and Location
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY

Mother: Living/Deceased Father: Living/Deceased Number of Children _____ Ages _____

Please check the following medical conditions that have occurred in your family

DISEASE	Father	Mother	Blood Rel.	DISEASE	Father	Mother	Blood Rel.
Allergies	☐	☐	☐	Heart Disease	☐	☐	☐
Arthritis	☐	☐	☐	High blood pressure	☐	☐	☐
Asthma	☐	☐	☐	Lung Disease	☐	☐	☐
Cancer	☐	☐	☐	Malignant melanoma	☐	☐	☐
Diabetes	☐	☐	☐	Psoriasis	☐	☐	☐
Eczema	☐	☐	☐	Rheumatoid arthritis	☐	☐	☐
Glaucoma	☐	☐	☐	Bleeding tendency	☐	☐	☐
Hayfever	☐	☐	☐	Skin Cancer	☐	☐	☐
Blood disorders	☐	☐	☐	Tuberculosis	☐	☐	☐

SOCIAL HISTORY: CHECK ALL THAT APPPLY

Do you smoke socially? Yes or No (PLEASE CIRCLE ONE)

Do you smoke? __No __Yes-frequency_____ Do you use recreational drugs? __No Yes-frequency ____

Do you drink alcohol? __No ___Yes-frequency_____ Hobbies: _____

HEALTH HISTORY QUESTIONS:

Have you recently had a mammogram? If yes, when _____Where_____ ___Yes ___No
Results _____
Have you been advised to take antibiotics before any surgery or dental work?..... ___Yes ___No
If yes, what is the reason _____
Do you take blood thinners or anticoagulants or aspirin? …… ___Yes ___No
If yes, which ones _____
Do you take tranquilizers or sedatives? …… ___Yes ___No
If yes, which ones _____
Are you currently taking insulin? ……. ___Yes ___No
Are you currently taking antibiotics? ……... ___Yes ___No
If yes, which ones _____
Are you currently taking Birth Control pills? …….. ___Yes ___No
Are you currently pregnant? …… ___Yes ___No
Are you planning to become pregnant in the near future? ……... ___Yes ___No
Are you currently taking vitamins? …….. ___Yes ___No
If yes, which ones _____
Did you ever take cortisone either by mouth or injection? …….. ___Yes ___No
Have you ever had a blood transfusion? …….. ___Yes ___No
If yes, reason and date _____
Have you ever been examined by a Dermatologist before? ……. ___Yes ___No
If yes, for what condition _____
Have you ever been treated for the same condition for which you are being seen? ……. ___Yes ___No
If yes, please list doctors names and addresses _____
Do you, or anyone in your family, form excessive scar tissue? …… ___Yes ___No
Have you ever had cosmetic surgery? …… ___Yes ___No
If yes, what type _____
Are you currently applying hydrocortisone, cortisone or any other medication to the skin? …… ___Yes ___No
Is there any other information that you feel is important for the doctor in evaluating your medical condition? …….. ___Yes ___No
If yes, please explain _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her/his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

****I have reviewed this patient health history form: _____ Date _____**