

# 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**

- |  |  |   |  |
|--|--|---|--|
| <b>GENERAL</b><br><input type="checkbox"/> Depression<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Fever<br><input type="checkbox"/> Headaches<br><input type="checkbox"/> Loss of weight<br><input type="checkbox"/> Nervousness<br><input type="checkbox"/> Sweats<br><input type="checkbox"/> Fainting | <b>MUSCLE/JOINT/BONE</b><br><input type="checkbox"/> Joint Replacement<br><input type="checkbox"/> Pain<br><input type="checkbox"/> Surgery<br><input type="checkbox"/> Weakness | <b>CARDIOVASCULAR</b><br><input type="checkbox"/> Chest Pain<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Irregular Heartbeat<br><input type="checkbox"/> Low Blood Pressure<br><input type="checkbox"/> Pacemaker<br><input type="checkbox"/> Poor Circulation<br><input type="checkbox"/> Shortness of Breath<br><input type="checkbox"/> Swelling of Ankles<br><input type="checkbox"/> Trouble Clotting<br><input type="checkbox"/> Varicose Veins | <b>SKIN</b><br><input type="checkbox"/> Bruise easily<br><input type="checkbox"/> Change in Moles<br><input type="checkbox"/> Cold Sores, fever<br><input type="checkbox"/> Blisters<br><input type="checkbox"/> Hives<br><input type="checkbox"/> Infection<br><input type="checkbox"/> Itching<br><input type="checkbox"/> Rash<br><input type="checkbox"/> Scars, Keloids<br><input type="checkbox"/> Sore that won't heal<br><input type="checkbox"/> Eczema<br><input type="checkbox"/> Psoriasis<br><input type="checkbox"/> Skin Cancer<br><input type="checkbox"/> Basal Cell Carcinoma<br><input type="checkbox"/> Squamous Cell Carcinoma<br><input type="checkbox"/> Melanoma |
| <b>GENITO-URINARY</b><br><input type="checkbox"/> Painful Urination<br><input type="checkbox"/> Menstrual Problems   | <b>EARS/NOSE/THROAT</b><br><input type="checkbox"/> Hay Fever<br><input type="checkbox"/> Nosebleeds<br><input type="checkbox"/> Sinus Problems                                  | <b>BREAST PROBLEMS</b><br><input type="checkbox"/> Tender Breasts<br><input type="checkbox"/> Discharge from Nipples<br><input type="checkbox"/> Lumps or recent change in size   |  |

Please explain any positive response: \_\_\_\_\_

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

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> AIDS<br><input type="checkbox"/> Alcoholism<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Anorexia<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Bleeding disorders<br><input type="checkbox"/> Breast Lump<br><input type="checkbox"/> Bulimia<br><input type="checkbox"/> Cancer | <input type="checkbox"/> Chemical Dependency<br><input type="checkbox"/> Chicken Pox<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Emphysema<br><input type="checkbox"/> Epilepsy<br><input type="checkbox"/> Fibrocystic Disease<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Goiter<br><input type="checkbox"/> Gout<br><input type="checkbox"/> Hay Fever<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis<br><input type="checkbox"/> Herpes<br><input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> HIV Positive<br><input type="checkbox"/> Hormone Problems<br><input type="checkbox"/> Joint Replacement<br><input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> Liver Disease<br><input type="checkbox"/> Lung Disease<br><input type="checkbox"/> Melanoma<br><input type="checkbox"/> Migraine Headaches<br><input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Moles Removed<br><input type="checkbox"/> Mononucleosis<br><input type="checkbox"/> Multiple Sclerosis<br><input type="checkbox"/> Pacemaker<br><input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Thyroid Problems<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Typhoid Fever<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Other |
|---|--|--|---|

Please explain: \_\_\_\_\_

**MEDICATIONS:** List those you are currently taking (List type, dosage and duration) \_\_\_\_\_

- |  |  |   |   |
|--|--|---|---|
| <b>DRUG ALLERGIES</b><br><input type="checkbox"/> Food<br><input type="checkbox"/> Anesthetics<br><input type="checkbox"/> Codeine<br><input type="checkbox"/> Penicillin<br><input type="checkbox"/> Tetracycline<br><input type="checkbox"/> Novocaine | <b>NON-DRUG ALLERGIES</b><br><input type="checkbox"/> Aspirin<br><input type="checkbox"/> Erythromycin<br><input type="checkbox"/> Sulfa<br><input type="checkbox"/> Lidocaine<br><input type="checkbox"/> Other<br>List type of allergic reaction _____ | <b>HORMONE REPLACEMENT/BIRTH CONTROL</b><br>Are you taking any kind of hormone replacement's _____<br>Are you taking any kind of birth control _____<br>If yes, please list _____ | <b>DIET MEDICATIONS</b><br>Currently taking or within this year any <b>diet or herbal medications?</b> _____<br>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*

<u>DISEASE</u>	<u>Father</u>	<u>Mother</u>	<u>Blood Rel.</u>	<u>DISEASE</u>	<u>Father</u>	<u>Mother</u>	<u>Blood Rel.</u>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malignant melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SOCIAL HISTORY: CHECK ALL THAT APPLY**

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 \_\_\_\_\_**