

**WEST COUNTY DERMATOLOGY, INC.**

**HEALTH HISTORY FORM**

PLEASE PRINT

Name \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Pharmacy \_\_\_\_\_ Pharmacy Address \_\_\_\_\_

Pharmacy Phone # \_\_\_\_\_ Pharmacy Fax # \_\_\_\_\_

Reason for visit: \_\_\_\_\_

**Medical History** (conditions for which you are followed by a physician or hospitalized in past):

- |  |  |  |                                       |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Skin Cancer         | <input type="checkbox"/> Hypertension  | <input type="checkbox"/> Gastric Reflux  | <input type="checkbox"/> HIV/AIDS     |
| <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Heart Attack  | <input type="checkbox"/> Lupus           | <input type="checkbox"/> Hepatitis    |
| <input type="checkbox"/> Artificial Joint(s) | <input type="checkbox"/> Blood Clots   | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Emphysema     | <input type="checkbox"/> Stroke          | <input type="checkbox"/> _____        |
| <input type="checkbox"/> Latex Allergy       | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____        |

**Medications** (Please List)  Aspirin/Coumadin  Birth Control Pills  Antacids  Prednisone

**Allergies to medications:**  None  Penicillin  Sulfa  Codeine  Lidocaine

**Family History:**  Skin Cancer  Melanoma  Abnormal Moles  Psoriasis

**Current or past problems with:** (Review of systems)

**General Health:** \_\_\_\_\_

Do you take antibiotics before dental work? \_\_\_\_\_ Why? \_\_\_\_\_

Do you smoke?  Yes  No Do you drink alcohol?  Yes  No How much? \_\_\_\_\_

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Acne              | <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Kidney trouble       | <input type="checkbox"/> Thyroid Disease      |
| <input type="checkbox"/> Psoriasis         | <input type="checkbox"/> Short of Breath  | <input type="checkbox"/> Headache/Dizziness   | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Eczema            | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Seizures             | <input type="checkbox"/> Anemia               |
| <input type="checkbox"/> Keloids           | <input type="checkbox"/> Chronic Cough    | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Bleeding disorder    |
| <input type="checkbox"/> Cold Sores/Herpes | <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Muscle weakness      | <input type="checkbox"/> Easy Bruising        |
| <input type="checkbox"/> Cataract/Blind    | <input type="checkbox"/> Abdominal pain   | <input type="checkbox"/> Joint Swelling       | <input type="checkbox"/> Blood Disease        |
| <input type="checkbox"/> Ears/Nose/Throat  | <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> Depression/Anxiety   | <input type="checkbox"/> Seasonal Allergies   |
| <input type="checkbox"/> Heart attack      | <input type="checkbox"/> Nausea/Vomiting  | <input type="checkbox"/> Psychiatric disorder | <input type="checkbox"/> Immunologic Disorder |

**Additional Information:** \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Personnel: \_\_\_\_\_ Date: \_\_\_\_\_

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