

WEST COUNTY DERMATOLOGY, INC.

HEALTH HISTORY FORM

PLEASE PRINT

Name _____ DOB: ____/____/____ Age: _____

Referring Physician _____ Primary Care Physician _____

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: _____