**HEALTH HISTORY FORM**

|  |  |  |
| --- | --- | --- |
| Today’s Date: | Primary Care Provider / Address: | |
| **PATIENT INFORMATION** | | |
| Last Name: First Name: Middle Initial: Address: | | Date of Birth:  / /  Phone #: |
| Primary Language: □ English □ Arabic □ French □ German □ Mandarin □ Spanish □ Russian □ Other | | |
| Race: □ American Indian □ Asian □ African American or Black □ Native Hawaiian/Other Pacific □ White □ Unknown □ Other | | |
| Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino | | |
| Primary Pharmacy: Address: | | |
| **\*\*Prescription Benefits Provided By (i.e. Express Scripts, Medco, etc.):** | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **REASON FOR TODAY’S VISIT** | | | |
| Concern: | Location: | Duration: | Prior Treatments: |
| Concern: | Location: | Duration: | Prior Treatments: |

|  |
| --- |
| **PAST MEDICAL HISTORY** |
| **CRITICAL INFORMATION MEDICAL HISTORY**  Adhesive tape / latex allergy □ Yes □ No Abnormal moles □ Yes □ No  Anticoagulant treatment □ Yes □ No Abnormal scars □ Yes □ No  Artificial heart valves □ Yes □ No Acne □ Yes □ No  Artificial joint □ Yes □ No Actinic keratosis □ Yes □ No  Bacitracin / Neosporin allergy □ Yes □ No Arthritis □ Yes □ No  Bleeding disorders □ Yes □ No Asthma □ Yes □ No  Breast cancer / Other cancer □ Yes □ No Diabetes □ Yes □ No  Epilepsy □ Yes □ No Eczema □ Yes □ No  Epinephrine sensitivity □ Yes □ No Hay fever □ Yes □ No  Fainting / syncope □ Yes □ No Heart disease □ Yes □ No  Hepatitis □ Yes □ No HSV / cold sore □ Yes □ No  HIV positivity □ Yes □ No Kidney disease □ Yes □ No  Hypertension □ Yes □ No Lupus □ Yes □ No  Immunosuppressive therapy □ Yes □ No Multiple sclerosis □ Yes □ No  Local anesthetics allergy □ Yes □ No Parkinson’s disease □ Yes □ No  Lymphoma □ Yes □ No Poor wound healing □ Yes □ No  Memory problems □ Yes □ No Psoriasis □ Yes □ No  Mitral valve prolapse □ Yes □ No Rosacea □ Yes □ No  MRSA □ Yes □ No Seasonal allergies □ Yes □ No  Organ transplant □ Yes □ No Thyroid disease □ Yes □ No  Pacemaker / defibrillator □ Yes □ No Warts □ Yes □ No  Pre-op/pre-dental antibiotics □ Yes □ No Other (specify below) □ Yes □ No |

|  |  |
| --- | --- |
| **SKIN CANCER HISTORY** | |
| Do you have a history of melanoma? | * Yes □ No |
| Do you have a history of other skin cancer(s)? | * Yes □ No |
| Type(s) / Location(s): |  |

|  |  |  |
| --- | --- | --- |
| **CURRENT MEDICATIONS** | | |
| Medication: | Medication: | Medication: |
| Medication: | Medication: | Medication: |
| Medication: | Medication: | Medication: |
| Medication: | Medication: | Medication: |

|  |  |
| --- | --- |
| **MEDICATION ALLERGIES** | |
| Do you have any medication allergies: | * Yes □ No |
| List allergies: | |

|  |  |
| --- | --- |
| **FOR WOMEN ONLY** | |
| Are you pregnant? | * Yes □ No |
| Are you breastfeeding? | * Yes □ No |
| Are you on birth control? | * Yes □ No |
| Do you have regular menstrual cycles? | * Yes □ No |

|  |  |
| --- | --- |
| **FAMILY HISTORY OF SKIN CANCER** | |
| Do you have a family history of melanoma? | * Yes □ No |
| Do you have a family history of other skin cancer(s)? | * Yes □ No |
| Types: | |

|  |  |
| --- | --- |
| **SOCIAL HISTORY** | |
| Occupation: | **Specify:** |
| Do you use sunscreen? | * None □ Daily □ Occasionally |
| Tanning bed use? | * None □ Current □ Previous |
| What are your hobbies? | |
| Do you have any other medical problems or conditions? | |

|  |  |  |
| --- | --- | --- |
| **TOBACCO** | | |
| Do you use tobacco? | | * Yes □ No |
| **Please check on what applies below**: | | |
| Never smoker □ | Light tobacco smoker □ | Smoker, current status unknown □ |
| Former smoker □ | Currently every day smoker □ |  |
| Unknown if ever smoked □ | Heavy tobacco smoker □ |  |

|  |  |  |
| --- | --- | --- |
| **ALCOHOL** | | |
| Alcohol consumption? | | * Socially □ Moderate □ Heavy |
| **Please check on what applies below**: | | |
| Never □ | 2-3 / Week □ | No screening □ |
| Monthly or less □ | 4+ / Week □ | Number of drinks, **Specify: \_** |
| 2-4 / Month □ | Medical exclusion □ |  |

|  |
| --- |
| **ADDITIONAL SYMPTOMS** |
| Fever □ Yes □ No Shortness of breath □ Yes □ No Swollen □ Yes □ No Chills □ Yes □ No Nausea / vomiting □ Yes □ No lymph nodes  Fatigue □ Yes □ No Abdominal pain □ Yes □ No Joint pain □ Yes □ No Unintentional □ Yes □ No Constipation □ Yes □ No Rash / itch □ Yes □ No weight loss Diarrhea □ Yes □ No Headache □ Yes □ No  Weight gain □ Yes □ No Heartburn □ Yes □ No Dizziness □ Yes □ No Eye Irritation □ Yes □ No Easy bruising □ Yes □ No Anxiety □ Yes □ No Chronic cough □ Yes □ No Blood clots □ Yes □ No Depression □ Yes □ No |

|  |  |
| --- | --- |
| **PORTAL** | |
| Are you interested in Portal Access to your health information? | * Yes □ No |
| If yes, please **provide us with your E-mail**: | |

|  |  |  |
| --- | --- | --- |
| **COSMETIC PROCEDURES** | | |
| Are you interested in cosmetic procedures? | | * Yes □ No |
| **Please check on what applies below**: | | |
| Acne Scar Treatment □ | Brown Spot Removal □ | Leg Vein Treatment □ |
| Benign Lesion/Mole Removal □ | Chemical Peel □ | Photodamage IPL Treatment □ |
| Blue Light Treatment (PDT) □ | Filler □ | Photofacial □ |
| Botox □ | Hair Removal □ | Skin Rejuvenation □ |
| Broken Vessels □ | Laser Resurfacing □ | Stretch mark Treatment □ |

|  |  |  |
| --- | --- | --- |
| **MEDICAL GRADE SKIN CARE PRODUCTS** | | |
| Are you interested in medical grade skin care products? | | * Yes □ No |
| **Please check on what applies below**: | | |
| Acne Products □ | Facial Moisturizers □ | Night Restorative Cream □ |
| Antioxidant Cleanser □ | Firming Neck Cream □ | Retinol Serum □ |
| Clarifying Brightening Polish □ | Gentle Cleanser □ | Skin Rejuvenation Products □ |
| Collagen Rejuvenation Serum □ | Green Tea Antioxidant Body Lotion □ | Sunscreens □ |