**HEALTH HISTORY FORM**

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| 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.):** |

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

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| **PAST MEDICAL HISTORY** |
| **CRITICAL INFORMATION MEDICAL HISTORY**Adhesive tape / latex allergy □ Yes □ No Abnormal moles □ Yes □ NoAnticoagulant treatment □ Yes □ No Abnormal scars □ Yes □ NoArtificial heart valves □ Yes □ No Acne □ Yes □ NoArtificial joint □ Yes □ No Actinic keratosis □ Yes □ NoBacitracin / Neosporin allergy □ Yes □ No Arthritis □ Yes □ NoBleeding disorders □ Yes □ No Asthma □ Yes □ NoBreast cancer / Other cancer □ Yes □ No Diabetes □ Yes □ NoEpilepsy □ Yes □ No Eczema □ Yes □ NoEpinephrine sensitivity □ Yes □ No Hay fever □ Yes □ NoFainting / syncope □ Yes □ No Heart disease □ Yes □ NoHepatitis □ Yes □ No HSV / cold sore □ Yes □ NoHIV positivity □ Yes □ No Kidney disease □ Yes □ NoHypertension □ Yes □ No Lupus □ Yes □ NoImmunosuppressive therapy □ Yes □ No Multiple sclerosis □ Yes □ NoLocal anesthetics allergy □ Yes □ No Parkinson’s disease □ Yes □ NoLymphoma □ Yes □ No Poor wound healing □ Yes □ NoMemory problems □ Yes □ No Psoriasis □ Yes □ NoMitral valve prolapse □ Yes □ No Rosacea □ Yes □ NoMRSA □ Yes □ No Seasonal allergies □ Yes □ NoOrgan transplant □ Yes □ No Thyroid disease □ Yes □ NoPacemaker / defibrillator □ Yes □ No Warts □ Yes □ NoPre-op/pre-dental antibiotics □ Yes □ No Other (specify below) □ Yes □ No |

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| **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): |  |

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

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

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

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| **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? |

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| **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 □ |  |

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| **ALCOHOL** |
| Alcohol consumption? | * Socially □ Moderate □ Heavy
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| **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 □ |  |

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| **ADDITIONAL SYMPTOMS** |
| Fever □ Yes □ No Shortness of breath □ Yes □ No Swollen □ Yes □ No Chills □ Yes □ No Nausea / vomiting □ Yes □ No lymph nodesFatigue □ 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 □ NoWeight 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 |

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

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| **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 □ |

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| **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 □ |