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

Adhesive tape / latex allergy	□ Yes	□ No
Anticoagulant treatment	□ Yes	□ No
Artificial heart valves	□ Yes	□ No
Artificial joint	□ Yes	□ No
Bacitracin / Neosporin allergy	□ Yes	□ No
Bleeding disorders	□ Yes	□ No
Breast cancer / Other cancer	□ Yes	□ No
Epilepsy	□ Yes	□ No
Epinephrine sensitivity	□ Yes	□ No
Fainting / syncope	□ Yes	□ No
Hepatitis	□ Yes	□ No
HIV positivity	□ Yes	□ No
Hypertension	□ Yes	□ No
Immunosuppressive therapy	□ Yes	□ No
Local anesthetics allergy	□ Yes	□ No
Lymphoma	□ Yes	□ No
Memory problems	□ Yes	□ No
Mitral valve prolapse	□ Yes	□ No
MRSA	□ Yes	□ No
Organ transplant	□ Yes	□ No
Pacemaker / defibrillator	□ Yes	□ No
Pre-op/pre-dental antibiotics	□ Yes	□ No

MEDICAL HISTORY

Abnormal moles	□ Yes	□ No
Abnormal scars	□ Yes	□ No
Acne	□ Yes	□ No
Actinic keratosis	□ Yes	□ No
Arthritis	□ Yes	□ No
Asthma	□ Yes	□ No
Diabetes	□ Yes	□ No
Eczema	□ Yes	□ No
Hay fever	□ Yes	□ No
Heart disease	□ Yes	□ No
HSV / cold sore	□ Yes	□ No
Kidney disease	□ Yes	□ No
Lupus	□ Yes	□ No
Multiple sclerosis	□ Yes	□ No
Parkinson's disease	□ Yes	□ No
Poor wound healing	□ Yes	□ No
Psoriasis	□ Yes	□ No
Rosacea	□ Yes	□ No
Seasonal allergies	□ Yes	□ No
Thyroid disease	□ Yes	□ No
Warts	□ 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 lymph nodes	□ Yes	□ No
Chills	□ Yes	□ No	Nausea / vomiting	□ Yes	□ No			
Fatigue	□ Yes	□ No	Abdominal pain	□ Yes	□ No	Joint pain	□ Yes	□ No
Unintentional weight loss	□ Yes	□ No	Constipation	□ Yes	□ No	Rash / itch	□ Yes	□ No
			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 □

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