Patient History Form

PATIENT NAME:____ **Date:**____________

Acct#:______________ DOB:____/____/____ Age:______ M/F:______ Height:_______ Weight:_______

ALLERGIES: Check ☑ No or Yes to the following (with description if applicable):

Adhesive Tape	❑ No ❑ Yes (describe)	___
Cosmetics / Jewelry	❑ No ❑ Yes (describe)	___
Cleansers / Detergents	❑ No ❑ Yes (describe)	___
Foods / Plants	❑ No ❑ Yes (describe)	___
Hay Fever / Asthma	❑ No ❑ Yes (describe)	___
Iodine Preps	❑ No ❑ Yes (describe)	___
Latex	❑ No ❑ Yes (describe)	___
Local Anesthesia	❑ No ❑ Yes (describe)	___
Medication / Drug Allergies	❑ No ❑ Yes (describe)	___
Shampoos / Soaps / Lotions	❑ No ❑ Yes (describe)	___
Other	❑ No ❑ Yes (describe)	___

PAST/RECENT MEDICAL HISTORY:

Circle applicable conditions and Explain if Necessary

	No	Yes	Please Explain:
Arthritis (Rheumatoid, Osteo, Other _________)	❑	❑	
Cardiac (Angina, Arrhythmia, Failure, MVP, Murmur, Pacemaker)	❑	❑	
Endocrine (Diabetes, Thyroid, Other _________)	❑	❑	
Hypertension / Hypotension	❑	❑	
Kidney (Failure, Dialysis, Other _________)	❑	❑	
Liver (Hepatitis, Jaundice, Liver Problems, Other _________)	❑	❑	
Lung (Asthma, Emphysema, Pneumonia, Tuberculosis)	❑	❑	
Neuro (Headaches, Migraines, Seizures, Other _________)	❑	❑	
Psychiatric (Depression, Bi-Polar, Schizophrenia, etc.)	❑	❑	
Hospitalizations (please explain)	❑	❑	
Other (non skin related conditions, ex. Cancers, Lupus, Anemia, Bleeding Problems, etc.)	❑	❑	

SURGICAL HISTORY: Please list any past or present surgeries you have experienced.

PAST / PRESENT SURGERIES:	YEAR:

MEDICATIONS:

Do you require prophylactic antibiotics for dental work or surgery? ❑ **No** ❑ **Yes**

(If Yes please list the NAME, DOSE, & FREQUENCY) ______________________________

Please list ALL other medications (prescription or over-the-counter) that you are now taking or have taken in the past 12 months:

Note: If you are on more than 5 medications please attach an additional sheet.

MEDICATION / Strength	How Often	Check ☑ when Medication was STARTED:
		❑ 0-3 months ❑ 4-6 months ❑ over 6 months ago
		❑ 0-3 months ❑ 4-6 months ❑ over 6 months ago
		❑ 0-3 months ❑ 4-6 months ❑ over 6 months ago
		❑ 0-3 months ❑ 4-6 months ❑ over 6 months ago
		❑ 0-3 months ❑ 4-6 months ❑ over 6 months ago

CONTINUED ON OTHER SIDE ➔

NAME:____ **DOB:**____/____/____ **Acct#:**__________

FAMILY HISTORY: Check ☑ following conditions that have occurred in your family

	MOTHER	FATHER	BLOOD RELATIVE
Allergies	❑	❑	❑
Arthritis	❑	❑	❑
Asthma	❑	❑	❑
Cancer	❑	❑	❑
Diabetes	❑	❑	❑
Eczema	❑	❑	❑
Hayfever	❑	❑	❑

	MOTHER	FATHER	BLOOD RELATIVE
Heart Disease	❑	❑	❑
High Blood Pressure	❑	❑	❑
Lung Disease	❑	❑	❑
Lupus	❑	❑	❑
Malignant Melanoma	❑	❑	❑
Psoriasis	❑	❑	❑
Skin Cancer	❑	❑	❑
What type? (if known)	________	________	________

SOCIAL HISTORY:

Do you live alone? ❑ No ❑ Yes

Do you drink alcohol? ❑ No ❑ Yes (frequency) ________

Do you smoke? ❑ No ❑ Yes (frequency) _________

Do you use recreational drugs? ❑ No ❑ Yes (frequency) ________

Have you ever used a Tanning Bed? ❑ No ❑ Yes

If Yes, when was the last time? ________________ and how frequent was the use?______________

Do you have pets? ❑ No ❑ Yes (describe) ____

Occupation ________________________________ Hobbies/Leisure Activities _____________________________

FEMALES:

Are you pregnant? ❑ No ❑ Yes (Due Date: ____/____/____)

Are you on Birth Control? ❑ No ❑ Yes (Type: ____________)

SKIN PERTINENT PROBLEMS: Check ☑ any past or present skin conditions:

- ❑ Abnormal or Changing Moles
- ❑ Acne
- ❑ Eczema
- ❑ Excessive Scarring
- ❑ Frequent Sun Exposures
- ❑ Herpes
- ❑ Hives
- ❑ Keloids
- ❑ Previous X-Ray Treatments
- ❑ Psoriasis
- ❑ Rash
- ❑ Recent or Progressive Hair Loss
- ❑ Skin Cancer (Type: _______________)
- ❑ Other_____________________________

For any checked ☑ boxes above, please explain when the condition appeared, what caused the condition (if known), and how the condition was (or is currently being) treated (if applicable).

____

____

____

Describe Known Family History of Skin Problems:	Relationship:

CONSENT FOR TREATMENT:

I hereby consent to all surgical procedures and treatment, including, but not limited to, any laboratory and biologic tests and administration of anesthetics, which are deemed appropriate and necessary for the treatment of the disorder about which I have consulted this office (I understand that this consent does NOT limit my right to refuse any treatment or procedure if I so choose). I am aware that a scar may result from any surgical procedure I may have, and that the type of scar cannot be determined before surgery. I further agree that the information listed on this form that I have provided the attending nurse/doctor is correct to the best of my knowledge.

______________________________________ ____ / ____ / ____

Signature of Patient or Guardian Date

___________________________ ____ / ___ / ______

Signature of Reviewing Nurse Date

___________________________ ____ / ___ / ______

Signature of Reviewing Physician Date