PATIENT HEALTH HISTORY

NAME_____BIRTHDATE_____COPAYMENT $_____

PHONE(H)_____(W)_____ INS.CO_____

DRUG ALLERGIES Y/N IF YES, TO WHAT? WHAT HAPPENS_____

_____

PLEASE LIST ALL MEDICATIONS YOU TAKE DAILY, INCLUDING OVER THE COUNTER HERBS/VITAMINS/SUPPLEMENTS/COUMADIN/ASPIRIN AND DATE WHICH YOU BEGAN:

_____

_____

_____

WHAT IS YOUR GENERAL HEALTH? (CIRCLE ONE) EXCELLENT/GOOD/FAIR/POOR

HISTORY OF HEPATITIS? Y/N IF YES,WHAT TYPE & WHEN_____
HISTORY OF TB? Y/N IF YES,WHEN? _____

PLEASE CHECK OFF THE MEDICAL CONDITIONS YOU HAVE:

DIABETES	THYROID DISORDER	GASTROINTESTINAL
HEART DISEASE	CANCER	LIVER
RENAL DISEASE	HIGH BLOOD PRESSURE	OTHER

HAVE YOU HAD ANY PRIOR MAJOR OR MINOR SURGERIES? Y/N IF YES LIST:

_____

HAVE YOU HAD ANY PROBLEMS WITH BLEEDING ____ BRUISING ____ HEALING OF SCARS____
KELOIDS ____DISCOLORATION_____
ARTIFICIAL GRAFTS Y/N, WHERE_____ BONE REPLACEMENTS Y/N WHERE_____
HEART VALVE PROBLEMS Y/N. HAVE YOU BEEN TOLD YOU NEED PROPHYLACTIC ANTIBIOTICS BEFORE SURGERY OR DENTAL WORK Y/N

I AM HERE TODAY BECAUSE I HAVE A (PLEASE CIRCLE)

A.RASH B. LESION growth,mole etc) C. WARTS D. ACNE E. COSMETIC CONCERN

THE AREA LISTED ABOVE IS LOCATED _____

PLEASE COMPLETE THE ENTIRE FORM!!!!!!!!!!

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ON THE OTHER SIDEOF THIS PAGE, PLEASE COMPLETE THE AREAS PERTAINING TO WHY YOU ARE HERE TODAY. SKIP THE AREAS THAT DO NOT APPLY

A: RASH

HOW LONG HAS THE RASH BEEN PRESENT? _____

HOW LONG HAS IT BEEN FLARING UP? _____

ANY PRIOR TREATMENTS Y/N IF YES WHAT TYPE, TOPICAL/PILLS/OTHER

LIST HERE: _____

_____

B: LESION

HOW LONG HAS THE LESION BEEN PRESENT? _____

BLEEDS? Y/N CRUSTS Y/N ITCHY Y/N CHANGE IN SIZE/SHAPE Y/N CHANGE COLOR Y/N

IS THERE A PERSONAL HISTORY OF SKIN CANCER? Y/N IF YES, WHEN AND WHERE?

TREATED HOW?_____

IS THERE A FAMILY HISTORY OF SKIN CANCER? Y/N IF YES, WHO HAD IT, WHEN AND WHERE?

_____

C: WARTS

HOW LONG HAVE THE WARTS BEEN PRESENT? WHERE ARE THEY?_____

ANY PRIOR TREATMENTS Y/N IF YES WHAT TYPE, TOPICALS (ACIDS, ALDARA)/PILLS/LIQUID NITROGEN/CUTTING OUT/LASER

LIST HERE: _____

D: ACNE OR ROSACEA

HOW LONG HAS THE ACNE/ROSACEA EXISTED?

_____

HOW LONG HAS IT BEEN FLARING UP? _____

ANY PRIOR TREATMENT? Y/N IF YES CIRCLE BELOW:

TOPICIALS:

CLEOCIN (GEL,SOL,PADS,LOTION)	RETIN A (CR.,GEL, MICRO)	KLARON LOTION
BENZOL PEROXIDES (GEL,WASH)	METROGEL(CREAM OR LOTION)	NORITATE CREAM
GLYCOLIC ACID	NOVACET LOTION	BENZAMYCIN
ERYTHOMYCIN (GEL, SOL,PADS)	DIFFERIN (GEL,SOLUTION,PADS)	

ORAL:

TETRACYCLINE/ ERYTHOMYCIN /ZITHROMAX/ DYNACIN (MINOCIN/MINOCYCLINE)

BACTRIM(SEPTRA)/MONODOX (DOXYCYCLINE)/ACCUTANE

IF FEMALE, ANSWER THE FOLLOWING:

DO YOU TAKE BIRTH CONTROL PILLS Y/N IF YES WHAT: _____

PREGNANT Y/N TRYING TO GET PREGNANT Y/N BREAST FEEDING Y/N

ARE MENSTRAL PERIODS OF NORMAL DURATION AND FREQUENCY? Y/N IF NO, PLEASE EXPLAIN: _____

E: COSMETIC:

REQUESTED PROCEDURE(S) OR AREA(S) OF CONCERN:_____

_____