U.S. DERMATOLOGY partners

HEALTH HISTORY

PATIENT INFORMATION

Name:		Date of Birth:	Date of Visit:
Preferred Language:		Occupation/Employer:	
PCP:		Referred By:	
Preferred Pharmacy:	City/Zip		Phone:
Ethnic Group: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer Not to Say ☐ Unknown	Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander		☐ White or Caucasian ☐ Other_______ ☐ Prefer Not to Say ☐ Unknown
Emergency Contact Name:			Phone:
Medical Power of Attorney:			Phone:

HEALTH HISTORY | Please check appropriate box (Y/N) as each applies to your current or past medical history:

*Artificial Heart Valve / Infection ☐ Y ☐ N
*Artificial Joint (Past 2 Years) ☐ Y ☐ N
*Hepatitis, Type: ______________________ ☐ Y ☐ N
*HIV/AIDS ☐ Y ☐ N
*MRSA Infection ☐ Y ☐ N
*Organ Transplant ☐ Y ☐ N
*Pacemaker/Defibrillator ☐ Y ☐ N
*Staph Bacterial Infection ☐ Y ☐ N
*Vasovagal Reaction (Fainting) ☐ Y ☐ N
*Premedication Prior to Procedures ☐ Y ☐ N
Antibiotics ________________________ ☐ Y ☐ N

*Accutane (Last 6 Months) ☐ Y ☐ N
Cold Sores/Herpes ☐ Y ☐ N
Diabetes ☐ Y ☐ N
Dementia ☐ Y ☐ N
High Blood Pressure ☐ Y ☐ N
Hyperthyroid ☐ Y ☐ N
Hypothyroid ☐ Y ☐ N
Autoimmune Condition ☐ Y ☐ N Type: ___________________________
Cancer (Other Than Skin) ☐ Y ☐ N Type: ___________________________
Radiation Treatment ☐ Y ☐ N When & Why: ______________________

Surgical Procedures (Within the Past 2 Years): ____
Do **you** wear sunscreen? ☐ Y ☐ N SPF: ____
*Have **you** had **melanoma** skin cancer? ☐ Y ☐ N Location(s) & date(s): ______________________
Have **you** had **basal cell carcinoma** skin cancer? ☐ Y ☐ N Location(s) & date(s): ______________________
Have **you** had **squamous cell carcinoma** skin cancer? ☐ Y ☐ N Location(s) & date(s): ______________________
Has **anyone in your family** had **melanoma** skin cancer? ☐ Y ☐ N Which relative(s): ______________________

ALLERGIES

Are you allergic to: **Drug Allergies / Reaction:**

*Adhesive ☐ Y ☐ N ____
*Epinephrine ☐ Y ☐ N ____
*Lidocaine ☐ Y ☐ N ____
*Antibiotic Ointment ☐ Y ☐ N ____
*Latex ☐ Y ☐ N ____

SOCIAL HISTORY

Alcohol Use:
☐ None
☐ < 1 Drink a Day
☐ 1-2 Drinks a Day
☐ 3 or More Per Day

Cigarette Smoking:
☐ Never Smoked
☐ Former Smoker
☐ Currently Smoke

CURRENT MEDICATIONS | List all current medications (including chemotherapy, over-the-counter meds, vitamins, herbal supplements):____

____

CURRENT SYMPTOMS OR CONDITIONS

Please describe your skin problem(s) & reason for today's visit:__________________________________
Area(s) involved: ___________________________ **How long have you had the problem(s):** ______________________

*Pregnant or Planning ☐ Y ☐ N
*Currently Breastfeeding ☐ Y ☐ N
*Recent Biologic Med. ☐ Y ☐ N
*Recent Chemotherapy ☐ Y ☐ N
*Problems with Bleeding ☐ Y ☐ N
*Immunosuppression ☐ Y ☐ N

Abnormal blood counts ☐ Y ☐ N
Abnormal scarring ☐ Y ☐ N
Enlarged lymph nodes ☐ Y ☐ N
Fever or chills ☐ Y ☐ N
Recent Illness ☐ Y ☐ N
Describe: ___________________________

Have you received the following vaccinations?
Flu (Oct – Mar Only) ☐ Y ☐ N
Pneumonia (65+ Years Only) ☐ Y ☐ N
Shingles (50+ Years Only) ☐ Y ☐ N

CONSENT

Patient Signature: ____ Date: ___________________ Dr Initials: _______ Staff Initials: ______