

GARDEN CITY DERMATOLOGY – HEALTH HISTORY

Last Name: _____ First Name: _____

Consult Requested by Doctor/PA/Nurse/Relative/Friend _____

Pharmacy Name: _____ Pharmacy Phone: _____

Describe your current skin problem: _____

How long have you had this problem? _____

Have you ever had it before? _____

Does it: Itch Ooze Burn Bleed Other _____

What are you using for it? _____

Have you recently stopped using any medications? _____

What treatment have you received in the past for this problem? _____

Have you seen another dermatologist? _____ Dr.'s Name: _____

Allergies to Medications: None _____

Current Medications: None Aspirin/Motrin/Advil Coumadin Birth Control Pills
 Vitamins Herbal Laxatives

REVIEW OF SYSTEMS [Please check if you have a history of]:

Allergic to Latex/Rubber/Nickel/Food	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Melanoma	<input type="checkbox"/>
Are You Breast Feeding	<input type="checkbox"/>	Immunologic Disease	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>
Blood/Bleeding Disorders	<input type="checkbox"/>	Infectious Disease	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>
Cancer (Non-Skin)	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Other _____	

Do you:

Have a pacemaker or defibrillator?	<input type="checkbox"/>	Form Keloids?	<input type="checkbox"/>
Take antibiotics prior to surgical procedures?	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>
Have an artificial joint or heart valve?	<input type="checkbox"/>	Do you plan to become pregnant soon?	<input type="checkbox"/>

List all your medical problems and past surgeries:

Please check if there is a family history of:

Acne	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Lupus	<input type="checkbox"/>
Actinic Keratosis	<input type="checkbox"/>	Contact Dermatitis	<input type="checkbox"/>	Melanoma	<input type="checkbox"/>
Alopecia	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Nail Disease	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Neoplasm	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Hair Loss	<input type="checkbox"/>	Precancerous Lesions	<input type="checkbox"/>
Basal Cell Carcinoma	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	Hives	<input type="checkbox"/>	Squamous Cell Carcinoma	<input type="checkbox"/>

Do you live alone?

Do you drink alcohol?

Do you smoke?

Occupation: _____ Hobbies/Leisure: _____

RB: _____