

FAIR OAKS SKIN CARE CENTER MEDICAL HISTORY FORM

Date _____ Name _____ Date of Birth _____ Sex M F
 Referring Physician _____ This appointment was Made by me Made by Dr. _____
 Reason for visit _____

Do you drink alcohol? Yes Never If yes, # drinks per day _____ Do you smoke? Yes No Quit _____ years ago If yes, # packs per day _____
 If female, are you pregnant, nursing, or think you may be pregnant? Y N What is your occupation? _____
 Do you use any illegal street drugs Y N If yes list _____
 What phone number is best to reach you to discuss test results? _____ Is it OK to leave a message for you at this number? Y N

<p>ALLERGIES: Please list any medication allergies that you have.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Are you allergic to any of the following? <input type="checkbox"/> Y <input type="checkbox"/> N Latex <input type="checkbox"/> Y <input type="checkbox"/> N Lidocaine <input type="checkbox"/> Y <input type="checkbox"/> N Iodine <input type="checkbox"/> Y <input type="checkbox"/> N Bee Stings <input type="checkbox"/> Y <input type="checkbox"/> N Vaccines <input type="checkbox"/> Y <input type="checkbox"/> N Eggs <input type="checkbox"/> Y <input type="checkbox"/> N Peanuts <input type="checkbox"/> Y <input type="checkbox"/> N Milk <input type="checkbox"/> Y <input type="checkbox"/> N Adhesive tape</p> <p>MEDICATIONS: Please list all medications you are taking. Include over the counter medications and any herbal, nutritional, or vitamin supplements.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>PAST SURGICAL HISTORY Please list any surgeries you have had and when they took place.</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;"><u>Procedure</u></td> <td style="width:50%;"><u>Year</u></td> </tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> </table>	<u>Procedure</u>	<u>Year</u>	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	<p>PAST MEDICAL HISTORY: Have you ever had any of the following conditions?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Cataracts <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma <input type="checkbox"/> Y <input type="checkbox"/> N Depression <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Disease <input type="checkbox"/> Y <input type="checkbox"/> N High Cholesterol <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure <input type="checkbox"/> Y <input type="checkbox"/> N Pulmonary Embolism <input type="checkbox"/> Y <input type="checkbox"/> N Deep Vein Thrombosis <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Heart Valve <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever <input type="checkbox"/> Y <input type="checkbox"/> N Stroke <input type="checkbox"/> Y <input type="checkbox"/> N Seizures/Epilepsy <input type="checkbox"/> Y <input type="checkbox"/> N Meningitis <input type="checkbox"/> Y <input type="checkbox"/> N Asthma <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema <input type="checkbox"/> Y <input type="checkbox"/> N Bronchitis <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis <input type="checkbox"/> Y <input type="checkbox"/> N Pneumonia <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease <input type="checkbox"/> Y <input type="checkbox"/> N Pancreatitis <input type="checkbox"/> Y <input type="checkbox"/> N Gout <input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis <input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement <input type="checkbox"/> Y <input type="checkbox"/> N HIV Infection/AIDS <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis B or C <input type="checkbox"/> Y <input type="checkbox"/> N Other (list): _____</p> <p>_____</p> <p>_____</p> <p>HISTORY OF SKIN DISEASE Please list any skin problems (including skin cancer) that you have had.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Do you have any of these symptoms?</p> <p>General: <input type="checkbox"/> Y <input type="checkbox"/> N Weight change <input type="checkbox"/> Y <input type="checkbox"/> N Fatigue/energy loss <input type="checkbox"/> Y <input type="checkbox"/> N Fevers <input type="checkbox"/> Y <input type="checkbox"/> N Heat or cold intolerance <input type="checkbox"/> Y <input type="checkbox"/> N Night sweats <input type="checkbox"/> Y <input type="checkbox"/> N Changes in nails <input type="checkbox"/> Y <input type="checkbox"/> N Hair loss</p> <p>Immune: <input type="checkbox"/> Y <input type="checkbox"/> N Frequent infections <input type="checkbox"/> Y <input type="checkbox"/> N Swollen glands <input type="checkbox"/> Y <input type="checkbox"/> N Runny nose</p> <p>Eyes: <input type="checkbox"/> Y <input type="checkbox"/> N Blurry vision <input type="checkbox"/> Y <input type="checkbox"/> N Blindness <input type="checkbox"/> Y <input type="checkbox"/> N Light sensitivity</p> <p>Skin: <input type="checkbox"/> Y <input type="checkbox"/> N Rash <input type="checkbox"/> Y <input type="checkbox"/> N Itching <input type="checkbox"/> Y <input type="checkbox"/> N Flushing <input type="checkbox"/> Y <input type="checkbox"/> N Color changes</p> <p>Ear/Nose/Throat: <input type="checkbox"/> Y <input type="checkbox"/> N Sinus problems <input type="checkbox"/> Y <input type="checkbox"/> N Sore throat <input type="checkbox"/> Y <input type="checkbox"/> N Changes in voice <input type="checkbox"/> Y <input type="checkbox"/> N Trouble swallowing</p> <p>Digestive: <input type="checkbox"/> Y <input type="checkbox"/> N Abdominal pain <input type="checkbox"/> Y <input type="checkbox"/> N Heartburn or ulcers <input type="checkbox"/> Y <input type="checkbox"/> N Loss of appetite <input type="checkbox"/> Y <input type="checkbox"/> N Nausea or vomiting <input type="checkbox"/> Y <input type="checkbox"/> N Constipation <input type="checkbox"/> Y <input type="checkbox"/> N Diarrhea <input type="checkbox"/> Y <input type="checkbox"/> N Bloating <input type="checkbox"/> Y <input type="checkbox"/> N Blood in stools</p> <p>Heart: <input type="checkbox"/> Y <input type="checkbox"/> N Murmur <input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain <input type="checkbox"/> Y <input type="checkbox"/> N Irregular heartbeat <input type="checkbox"/> Y <input type="checkbox"/> N Swelling in feet</p>	<p>Symptoms (contd.)?</p> <p>Respiratory: <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath <input type="checkbox"/> Y <input type="checkbox"/> N Wheezing <input type="checkbox"/> Y <input type="checkbox"/> N Cough</p> <p>Bladder: <input type="checkbox"/> Y <input type="checkbox"/> N Loss of bladder control <input type="checkbox"/> Y <input type="checkbox"/> N Frequent urination <input type="checkbox"/> Y <input type="checkbox"/> N Painful urination <input type="checkbox"/> Y <input type="checkbox"/> N Blood in urine</p> <p>Reproductive: <input type="checkbox"/> Y <input type="checkbox"/> N Menstrual problems <input type="checkbox"/> Y <input type="checkbox"/> N Miscarriages</p> <p>Hematologic: <input type="checkbox"/> Y <input type="checkbox"/> N Anemia <input type="checkbox"/> Y <input type="checkbox"/> N Bleed or bruise easily <input type="checkbox"/> Y <input type="checkbox"/> N Blood clots</p> <p>Musculoskeletal: <input type="checkbox"/> Y <input type="checkbox"/> N Muscle weakness <input type="checkbox"/> Y <input type="checkbox"/> N Muscle pain <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis or joint pain <input type="checkbox"/> Y <input type="checkbox"/> N Back or neck pain</p> <p>Neurological: <input type="checkbox"/> Y <input type="checkbox"/> N Headaches or migraines <input type="checkbox"/> Y <input type="checkbox"/> N Dizziness <input type="checkbox"/> Y <input type="checkbox"/> N Fainting <input type="checkbox"/> Y <input type="checkbox"/> N Numbness <input type="checkbox"/> Y <input type="checkbox"/> N Tingling</p> <p>Psychiatric: <input type="checkbox"/> Y <input type="checkbox"/> N Mood changes <input type="checkbox"/> Y <input type="checkbox"/> N Depression <input type="checkbox"/> Y <input type="checkbox"/> N Anxiety/Nervousness</p> <p>FAMILY HISTORY Has anyone in your family had skin cancer or other skin disease? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, please list.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<u>Procedure</u>	<u>Year</u>														
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Patient Signature _____ Date _____ Reviewed by MD _____ Date _____