

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, how many drinks per day _____ Do you smoke? Yes Never If yes, how many 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?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Latex</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Lidocaine</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Bee Stings</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Vaccines</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Eggs</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Peanuts</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Milk</p> <p><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> <p><u>Procedure</u> <u>Year</u></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>PAST MEDICAL HISTORY: Have you ever had any of the following conditions?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Cataracts</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Depression</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Diabetes</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Disease</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N High Cholesterol</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Pulmonary Embolism</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Deep Vein Thrombosis</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Artificial Heart Valve</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Stroke</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Seizures/Epilepsy</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Meningitis</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Asthma</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Emphysema</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Bronchitis</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Pneumonia</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Pancreatitis</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Gout</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N HIV Infection/AIDS</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis B or C</p> <p><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:</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Weight change</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Fatigue/energy loss</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Fevers</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Heat or cold intolerance</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Night sweats</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Changes in nails</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Hair loss</p> <p>Immune:</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Frequent infections</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Swollen glands</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Runny nose</p> <p>Eyes:</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Blurry vision</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Blindness</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Light sensitivity</p> <p>Skin:</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Rash</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Itching</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Flushing</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Color changes</p> <p>Ear/Nose/Throat:</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Sinus problems</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Sore throat</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Changes in voice</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Trouble swallowing</p> <p>Digestive:</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Abdominal pain</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Heartburn or ulcers</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Loss of appetite</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Nausea or vomiting</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Constipation</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Diarrhea</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Bloating</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Blood in stools</p> <p>Heart:</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Murmur</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Irregular heartbeat</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Swelling in feet</p>	<p>Symptoms (contd.)?</p> <p>Respiratory:</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Wheezing</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Cough</p> <p>Bladder:</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Loss of bladder control</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Frequent urination</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Painful urination</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Blood in urine</p> <p>Reproductive:</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Menstrual problems</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Miscarriages</p> <p>Hematologic:</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Anemia</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Bleed or bruise easily</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Blood clots</p> <p>Musculoskeletal:</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Muscle weakness</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Muscle pain</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Arthritis or joint pain</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Back or neck pain</p> <p>Neurological:</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Headaches or migraines</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Dizziness</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Fainting</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Numbness</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Tingling</p> <p>Psychiatric:</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Mood changes</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Depression</p> <p><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>
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Patient Signature _____ Date _____ Reviewed by MD _____ Date _____