Health History Form Label:

Name: _____

Date of Birth: _____Today's Date:_____

Do you have or have you ever had diseases or conditions of (please check Yes or No)

Respiratory:

Bronchitis	Yes ❑	No ❑
Emphysema	Yes ❑	No ❑
Asthma	Yes ❑	No ❑
Chronic Cough	Yes ❑	No ❑
Morning Cough	Yes ❑	No ❑
Shortness of Breath	Yes ❑	No ❑
Wheezing	Yes ❑	No ❑

Cardiovascular:

High Blood Pressure	Yes ❑	No ❑
Chest Pain	Yes ❑	No ❑
Heart Attack	Yes ❑	No ❑
Heart Murmur	Yes ❑	No ❑
Arrhythmia	Yes ❑	No ❑
Phlebitis	Yes ❑	No ❑
Hardening of the Arteries	Yes ❑	No ❑
Artificial Valve	Yes ❑	No ❑
Pacemaker	Yes ❑	No ❑

Other Systemic:

Hepatitis	Yes ❑	No ❑
Diabetes	Yes ❑	No ❑
Thyroid Problems	Yes ❑	No ❑
Kidney Disease	Yes ❑	No ❑
Dialysis	Yes ❑	No ❑
Bladder Problems	Yes ❑	No ❑
Gastrointestinal		
Stomach absorptive disorder	Yes ❑	No ❑
Nausea, vomiting, diarrhea when taking antibiotics	Yes ❑	No ❑
Yeast infection when taking antibiotics	Yes ❑	No ❑
Arthritis/joint Deformity	Yes ❑	No ❑
Artificial Joint	Yes ❑	No ❑
Convulsions	Yes ❑	No ❑
Epilepsy, Seizures	Yes ❑	No ❑
Fainting	Yes ❑	No ❑
Depression	Yes ❑	No ❑
HIV	Yes ❑	No ❑

List any **other diseases or conditions**:_____

List **Surgeries and Hospitalizations**: _____

List all **Medications**: (oral, injection, topical, including prescriptions, over-the-counter, and herbal.)_____

_____

List all **Allergies**: _____

_____

Skin: Have you ever had skin cancer? Yes ❑ No ❑ _____

Family history of skin cancer? Yes ❑ No ❑ _____

Do you have history of skin diseases? Yes ❑ No ❑ _____

Do you have problems healing? Yes ❑ No ❑

Do you develop keloid/raised scars after surgery? Yes ❑ No ❑

Do you bleed easily? Yes ❑ No ❑

Do you get rashes from Medication □ Food □ Environment □ Ointments □ Other □ _____

Social History:

Do you drink alcohol?	Yes ❑ _____ / day	No ❑
Do you smoke?	Yes ❑ How much?_____	No ❑
Do you use IV drugs?	Yes ❑ How much?_____	No ❑

What is your occupation?_____Hobbies? _____

(Women) Are you pregnant? Yes ❑ No ❑ Due date: ___/____/____ Breastfeeding Yes ❑ No ❑

Who is your primary care physician? _____

Have you ever seen a dermatologist before? Yes ❑ No ❑ Why?_____

Reason for your visit today? _____

PLEASE REVIEW AND UPDATE HEALTH HISTORY

_____Changes? Y/N List: _____

Patient Review; Sign and Date

_____Changes? Y/N List: _____

Patient Review; Sign and Date

_____Changes? Y/N List: _____

Patient Review; Sign and Date

_____Changes? Y/N List: _____

Patient Review; Sign and Date

_____Changes? Y/N List: _____

Patient Review; Sign and Date