GARDEN CITY DERMATOLOGY – HEALTH HISTORY

Last Name: _____First Name: _____Age_____

Name of Dr., NP, PA, who referred you here?_____

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 [ ] Is It Painful [ ] 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: _____

Past Medical History: _____ _____ _____

Allergies to Medications: [ ] None _____

Current Medications: **Please check**

[ ] None .
[ ] Birth Control Pills
[ ] Vitamins
[ ] Coumadin
[ ] Laxatives
[ ] Other _____

Single [ ] Married [ ] Divorced [ ] Widowed [ ] Other [ ]

REVIEW OF SYSTEMS – <u>YOUR PAST MEDICAL HISTORY</u> [Please check if you have a history of]:

[ ] Allergic to Latex/Rubber/Nickel/Food
[ ] Arthritis
[ ] Blood/Bleeding Disorders
[ ] Diabetes
[ ] Heart Disease
[ ] High Blood Pressure
[ ] Immunologic Disease
[ ] Infectious Disease
[ ] Kidney Disease
[ ] Liver Disease
[ ] Lung Disease
[ ] Melanoma
[ ] Skin Cancer
[ ] Skin Disease
[ ] Cancer (Non-Skin) _____
[ ] Skin Disease
[ ] Thyroid Disease
[ ] Other _____
_____
_____

[ ] Are you pregnant
[ ] Do you plan on becoming pregnant
[ ] Are you breast feeding
[ ] Do you have a pacemaker or defibrillator
[ ] Do you form keloids

List all your medical problems and past surgeries:

_____ _____
_____ _____
_____ _____

Please check if there is a **<u>FAMILY</u>** history of:

[ ] Acne
[ ] Actinic Keratosis
[ ] Alopecia
[ ] Arthritis
[ ] Asthma
[ ] Basal Cell Carcinoma
[ ] Breast Cancer
[ ] Cancer [Type]_____
[ ] Contact Dermatitis
[ ] Diabetes
[ ] Eczema
[ ] Hair Loss
[ ] Hay Fever
[ ] Hives
[ ] Lupus
[ ] Melanoma
[ ] Nail Disease
[ ] Neoplasm
[ ] Precancerous Lesions
[ ] Psoriasis
[ ] Squamous Cell Carcinoma

[ ] Do you smoke
[ ] Do you drink alcohol

Occupation: _____ Hobbies/Leisure: _____

Reviewed By: _____ Date: _____