Dermatology LTD – Health History/ROS

Name: _____ Date of Birth: ____/____/____ Date: _____

PLEASE CIRCLE YES OR NO IF YOU CURRENTLY OR PREVIOUSLY HAVE HAD ANY OF THE FOLLOWING:

HIV / AIDS YES or NO

HEPATITIS B or C YES or NO

PACEMAKER YES or NO

INTERNAL DEFIBRILLATOR YES or NO

ANESTHESIA / SURGICAL COMPLICATIONS YES or NO Explain: _____

TAKE AN ANTIBIOTIC PRIOR TO DENTAL PROCEDURES YES or NO

HEART VALVE OR JOINT REPLACEMENT YES or NO

ARE YOU CURRENTLY ON A BLOOD THINNER (EXAMPLE: Coumadin, Aspirin, Other) YES or NO Please List: _____

CLAUSTROPHOBIA YES or NO

HISTORY OF SKIN CANCER YES or NO Please List: _____

OTHER TYPES OF CANCER: _____

HAVE YOU EVER HAD A SEVERE SUNBURN? YES or NO

ARE YOU CURRENTLY TAKING BIRTH CONTROL PILLS? YES or NO Type: _____

ARE YOU CURRENTLY PREGNANT? YES or NO How many weeks? _____

HAVE YOU HAD A FLU SHOT THIS SEASON? YES or NO If YES: Month_____ Year _____

HAVE YOU HAD A PNEUMONIA SHOT? YES or NO If YES: Month_____ Year _____

ALLERGY OR SENSITIVITY TO **NUMBING MEDICATION** YES or NO Explain: _____

ALLERGIES (MEDICATION OR OTHER): YES or NO Please List: _____

_____

HEALTH HISTORY/ROS: (CHECK ALL THAT APPLY)

SKIN		**CARDIOVASCULAR**		**MUSCULOSKELETAL**	
Eczema		Heart Disease		Joint Pain	
Psoriasis		Heart Attack		Arthritis	
Itching		Mitral Valve Prolapse		Lupus	
Bruise Easily		Chest Pain		Muscle Weakness	
Keloids		Coronary Artery Disease		Neck Problems	
Frequent Sun Exposure		Irregular Heartbeat		**EYES**	
Cutaneous Lupus		Heart Murmur		Cataracts	
Abnormal Mole		High Blood Pressure		Blurry Vision	
Difficulty Healing		Low Blood Pressure		Glaucoma	
Hair Loss		**HEME**		**NEUROLOGICAL**	
Skin Cancer		Anemia		Seizures	
GASTROINTESTINAL		Excessive Bleeding		Dizziness	
Ulcer		Bruise Easily		Headaches	
Bloody Stool		Clots		Stroke / TIA	
Jaundice		**EARS**		Balance Problem	
Abdominal Pain		Ringing in Ears		Fainting	
CONSTITUTIONAL		Hearing Loss		Paralysis	
Night Sweats		**RESPIRATORY**		**CANCER**	
Unexpected Weight Loss		Shortness of Breath		Breast	
Unexpected Weight Gain		Tuberculosis		Colon	
Fatigue		Hay Fever		Lung	
Fever		Sinusitis		Prostate	
ENDOCRINE		Cough		**GENITOURINARY**	
Thyroid Disease		Asthma		Frequent Urination	
Type 1 Diabetes		Emphysema		Sexually Transmitted Disease	
Type 2 Diabetes					

CONTINUE ON REVERSE

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Name: _____ Date of Birth: ____/____/____ Date: _____

SURGICAL HISTORY: _____

_____

OTHER PERTINENT MEDICAL HISTORY: _____

_____

_____

SOCIAL HISTORY:

ALCOHOL USE: ____NONE ____DAILY ____SOCIALLY

ALCOHOL OR DRUG PROBLEM / ADDICTION? YES or NO Describe: _____

SMOKING ____NEVER ____CURRENT ____FORMER When did you quit? _____

OCCUPATION: _____ DO YOU WORK: INDOORS or OUTDOORS

_____

FAMILY HISTORY:

PLEASE LIST ANY FAMILY MEMBER WHO HAS HAD A SKIN CANCER AND WHICH TYPE (BASAL CELL, SQUAMOUS CELL, MELANOMA, UNSURE): _____

_____

OTHER FAMILY SKIN DISORDERS: _____

PHARMACY NAME, ADDRESS & PHONE: _____

_____

MEDICATIONS: Dosage, Frequency and Route (include vitamins, herbal and over the counter products):

MEDICATION	**DOSE (mg, ml, puff, cc, patch, etc)**	**FREQUENCY (once a day, twice a day, etc)**	**ROUTE (by mouth, on skin, in eye, etc)**
Example: *Tylenol*	*500mg*	*Every four hours*	*By Mouth*

PLEASE CONTINUE MEDICATION LIST ON A SEPARATE PIECE OF PAPER IF NEEDED*

_____

TO BE COMPLETED BY OUR STAFF:

BP _____ O2 _____ HR _____ WT _____ HT _____

CONTINUE ON REVERSE