HEALTH HISTORY

Date: _____

Update: _____

Update: _____

NAME: _____ Date of Birth: _____

TELEPHONE NUMBER to reach you with results: _____

Primary Care Physician: _____

May we leave medical information or test results on your answering machine?
□ Yes □ No

MEDICAL HISTORY: Please CHECK if you have ever had, and then CIRCLE any that you currently have)

General
□ Weight loss
□ Fever/chills
□ Fainting
□ Night sweats

Heart
□ Chest pains
□ Valve disease
□ Artificial valve
□ Heart murmur
□ Implanted defibrillator
□ Pacemaker
□ Cardiac stent
□ Congestive heart disease
□ Heart attack
□ High BP
□ High cholesterol

Lungs
□ Emphysema
□ Asthma
□ Positive TB test
□ Tuberculosis
□ COPD
□ Pulmonary embolism
□ Short of breath

Glands
□ Diabetes
□ Renal failure
□ Dialysis
□ Thyroid disorder
□ Guillan Barre

Muscles/bones
□ Artificial joints
□ Arthritis
□ Muscle weakness
□ Previous fractures
□ Muscular dystr.
□ Fibromyalgia

Psychiatric
□ Depression
□ Anxiety
□ Stress
□ ADD/ADHD
□ Dementia
□ Alzheimer's
□ Schizophrenia

Blood
□ Anemia
□ Bleed easily
□ Blood clots
□ Raynaud's syndr.
□ Circulatory probl.

Immune system
□ HIV
□ Hepatitis

Gastrointestinal
□ Gout
□ Gastritis
□ Acid reflux
□ Colitis
□ Ulcers
□ Heartburn

Eyes, ears, nose, throat
□ Chronic cough
□ Sinusitis
□ Hearing loss
□ Ear problems
□ Cataracts
□ Contact lenses
□ Glaucoma
□ Cochlear implant

Reproduct./urinary
□ Urinary infections
□ Kidney stones
□ Renal stent
□ Benign prostate hypertrophy
□ Hysterectomy

Brain/nervous
□ Seizures
□ Epilepsy
□ Tremors
□ CVA (stroke)
□ Neuropathy
□ Numbness/tingling
□ Headaches
□ Migraines
□ Multiple sclerosis

Other
□ Cancer (type) _____
□ Snore excessively
□ Sleep study
□ Apnea
□ CPAP
□ Other _____
_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY: □ Arthritis □ Diabetes □ High BP □ Heart disease □ Lung disease □ Stroke □ Cancer □ Other

Explain any checkmarks (include relationship to you): _____

VACCINATIONS: When was your last flu vaccination? ____/_____ (mo/yr) ____/_____ (mo/yr) ____/_____ (mo/yr)
Have you ever had the pneumococcal (pneumonia) vaccine? □ No □ Yes _____ (at what age)

SURGICAL/HOSPITALIZATION HISTORY (list all): _____

_____

SKIN HISTORY: Have you ever had (for checked items, list onset, duration, treatment)
□ Psoriasis _____ □ Eczema _____
□ Rosacea _____ □ Acne _____
□ Scleroderma _____ □ Other (specify) _____
□ Chronic sun exposure _____
□ Tanning bed exposure _____
□ Severe sun/tanning exposure (bad burns) _____
□ Chronic x-ray treatment _____
□ Skin cancer (specify type) _____

FAMILY SKIN HISTORY: Mother _____ Father _____ Children/siblings_____

SKIN TYPE: When exposed to sunlight, do you: □ Burn □ Burn then tan □ Tan only

OVER

CURRENT HEALTH

CURRENT MEDICATIONS: (Include creams, over the counter medications, herbals, vitamins, and all other supplements)

Name		Dose	How often
______________________________	□ Oral □ Topical □ Patch □ Other ______________	________________	__________
______________________________	□ Oral □ Topical □ Patch □ Other ______________	________________	__________
______________________________	□ Oral □ Topical □ Patch □ Other ______________	________________	__________
______________________________	□ Oral □ Topical □ Patch □ Other ______________	________________	__________
______________________________	□ Oral □ Topical □ Patch □ Other ______________	________________	__________
______________________________	□ Oral □ Topical □ Patch □ Other ______________	________________	__________
______________________________	□ Oral □ Topical □ Patch □ Other ______________	________________	__________
______________________________	□ Oral □ Topical □ Patch □ Other ______________	________________	__________
______________________________	□ Oral □ Topical □ Patch □ Other ______________	________________	__________

ALLERGIES: □ Medications (specify below) □ Foods □ Environment □ Latex

____

Do you use tobacco? □ No □ Cigarettes □ Other ______________ How much? __________ For how long? ____________

Do you drink alcohol? □ No □ Wine □ Beer □ Liquor Number of drinks/week ______ Number of drinks/occasion _____

Do you have a history of substance abuse? □ No □ Yes (past) □ Yes (current) ___________________________

CURRENT SKIN CONDITIONS/CONCERNS (specify onset, duration, any previous treatments):

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____

Patient signature: ____ Date: ____________________

Responsible party signature: ____ Date: ____________________

Update: _______________ _______________
Date Patient initials

Update: _______________ _______________
Date Patient initials