

Consulting Dermatologic Specialists

Patient Health History

**PLEASE PRINT

Occupation: _____

Name: _____ Birthdate: _____ Age: _____ Ht _____ Wt _____ M F

Please List All **Prescription** medications you are currently taking: _____

Please List All **Over the Counter** medications you are currently taking: _____

Are you allergic to any medications? yes no If yes, please describe: _____

Are you allergic to any of the following... dyes foods grasses yes no If yes, please describe: _____

Are you allergic to anything that touches your skin? yes no poison ivy jewelry If yes, please describe: _____

Are you currently being treated by a physician? yes no If yes, please describe: _____

Please mark yes or no

Atopic Dermatitis yes no

Eczema yes no

Psoriasis yes no

Accutane Use yes no

Hay Fever yes no

Asthma yes no

Anemia yes no

Artificial Joint yes no

Autoimmune Disease yes no

Glaucoma yes no

Diabetes yes no

High Blood Pressure yes no

Heart Attack/Heart Surgery yes no

Ulcer yes no

Heart Murmur yes no

Pacemaker/Artificial Heart Valve yes no

Frequent Skin Infections yes no

Fungal Infections yes no

Transplant yes no

Seizures or Epilepsy yes no

Thyroid Condition yes no

Women Only

Hysterectomy yes no

Pregnant or trying to conceive yes no

Nursing yes no

Taking Birth Control Pills yes no If no, and you have taken in past when did you stop taking? _____ (year)

Family History

Do you have a family history of : (immediate family, mother, father, brother, sister, children) _____

Asthma Eczema Atopic Dermatitis Psoriasis Melanoma Other Skin Cancer Thyroid Condition Rheumatoid Arthritis

I hereby state that I have completed the above information truthfully and correctly.

SIGNATURE

DATE

Reviewed by: _____ Reviewed By: _____ Reviewed By: _____

Initial/Date

Initial/Date

Initial/Date

