

Consulting Dermatologic Specialists

Patient Health History

Occupation: \_\_\_\_\_

**\*\*PLEASE PRINT**

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

**Pharmacy Information:** (Name, Address Phone #) \_\_\_\_\_

Reviewed by: \_\_\_\_\_  
Initial/Date

Reviewed By: \_\_\_\_\_  
Initial/Date

Reviewed By: \_\_\_\_\_  
Initial/Date