West County DERMATOLOGY

Health History Form

Patient Name: _____ **Date of Birth:** _____ **Date:** _____
Last First Middle

Pharmacy Address: _____ **Pharmacy Phone #:** _____ **Fax:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Primary Reason for Visit: ☐ **New Patient** ☐ **Current Patient Follow Up for:** _____
☐ **Rash** ☐ **Lesion(s)** ☐ **Routine Full Skin Exam**

#1: Onset: _____ Location(s): _____ Treatment: _____
#2: Onset: _____ Location(s): _____ Treatment: _____

MEDICAL HISTORY: (conditions for which you are followed by a physician or hospitalized in the past)

☐ **Check Here if NO Medical Conditions**

SKIN (normal ☐)
- ☐ Skin Cancer: type
- ☐ Eczema
- ☐ Acne: Prior treatment _____
- ☐ Psoriasis/Psoriatic Arthritis
- ☐ Herpes: Oral ☐ Genital ☐
- ☐ Shingles: Date_____
- ☐ Staph infection/MRSA
- ☐ Keloids
- ☐ Accutane: Year_____
- ☐ UV Light Treatments
- ☐ Abnormal Scars
- ☐ OTHER _____
- ☐ OTHER _____

CARDIOVASCULAR (normal ☐)
- ☐ Pacemaker/AICD
- ☐ Heart Murmur: Type _____
- ☐ Rheumatic Heart Disease
- ☐ Artificial Heart Valve
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ Stents/Angioplasty _____
- ☐ Irregular Heart Rhythm
- ☐ Peripheral Vascular Disease
- ☐ High Cholesterol
- ☐ OTHER _____
- ☐ OTHER _____

PULMONARY (normal ☐)
- ☐ Asthma
- ☐ Seasonal Allergies/Hay fever
- ☐ COPD/Emphysema
- ☐ Pulmonary Embolism
- ☐ Sleep Apnea/CPAP mask

HEMATOLOGIC (normal ☐)
- ☐ Anemia _____
- ☐ Bleeding Disorder
- ☐ Blood clots (legs)
- ☐ Leukemia/Lymphoma

ENDOCRINE (normal ☐)
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ OTHER _____

MUSCULOSKELETAL (normal ☐)
- ☐ Artificial Joints Date:_____
- ☐ Arthritis: Type _____

GASTROINTESTINAL (normal ☐)
- ☐ Acid Reflux/GERD
- ☐ Celiac Disease/Sprue
- ☐ Hepatitis: Type: _____
- ☐ Ulcerative Colitis/Crohn's
- ☐ Stomach Ulcer/Peptic Ulcer
- ☐ Liver/Gall Bladder Disease
- ☐ OTHER _____
- ☐ OTHER _____

IMMUNE/INFECTIOUS/CANCER (normal ☐)
- ☐ Cancer _____
- ☐ Radiation Treatments
- ☐ Chemotherapy
- ☐ Organ Transplant
- ☐ HIV/AIDS
- ☐ Tuberculosis: Date _____
- ☐ Lupus
- ☐ Other immune disorder

PSYCHIATRIC (normal ☐)
- ☐ Depression/Other Psychiatric
- ☐ Anxiety

NEUROLOGIC (normal ☐)
- ☐ Migraines
- ☐ Stroke
- ☐ Seizures
- ☐ Alzheimer's
- ☐ Multiple Sclerosis

OTHER (normal ☐)
- ☐ Pregnant/Nursing (currently)
- ☐ Glaucoma/Cataracts
- ☐ Kidney Disease/Dialysis
- ☐ Kidney Stones
- ☐ Gout
- ☐ Prone to Yeast Infections
- ☐ Planning pregnancy
- ☐ OTHER _____
- ☐ OTHER _____

1001 Chesterfield Pkwy East Suite #201, Chesterfield, MO 63017
Phone: (636) 532-2422 Fax: (636) 532-2425

West County DERMATOLOGY

Health History Form

SURGICAL HISTORY: Type/Date: _____

_____

DO YOU TAKE ANTIBIOTICS BEFORE DENTAL WORK? ☐ YES ☐ NO

Why? ☐ Joint Replacement ☐ Heart Murmur ☐ Heart Valve Replacement ☐ Other

ALLERGIES: ☐ NONE ☐ Tetracyclines ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Latex
☐ Tape/Band-Aids ☐ Lidocane ☐ Polysporin/Neosporin ☐ Betadine/Iodine ☐ Shellfish

OTHERS: _____

MEDICATIONS: Include DOSE and other over-the-counter, vitamins, herbals: ☐ NONE

☐ Aspirin mg	☐ Coumadin mg	☐ Plavix mg	☐ Pradaxa mg
☐ Antacids	☐ Birth Control	☐ Ibuprofen/NSAIDs	☐ Prednisone mg
1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.

FAMILY HISTORY: ☐ NONE

☐ Skin Cancer: type	☐ Melanoma	☐ Abnormal Moles	☐ Psoriasis
☐ Eczema	☐ Cancer	☐ Ulcerative Colitis	☐ Crohn's
☐ Celiac Sprue	☐ Dermatitis Herpetiformis	☐ Allergies	☐ Asthma
☐ Neurofibromatosis	☐ Multiple Sclerosis	☐ Neurologic Disease	☐ OTHER

HOBBIES: _____

SMOKING: ☐ Current Smoker/How Much? _____ ☐ Former Smoker (have stopped) ☐ Never

DRINKING: ☐ YES/How Much _____ ☐ NO **ILLICIT DRUG USE:** ☐ YES ☐ NO

CURRENT OR PAST PROBLEMS WITH: (Review of Systems) ☐ NONE

☐ Fever	☐ Chills	☐ Headaches	☐ Dizziness	☐ Nausea
☐ Vomiting	☐ Cough	☐ Short of Breath	☐ Chest Pain	☐ Abdominal Pain
☐ Constipation	☐ Diarrhea	☐ Blood in Stool	☐ Blood in Urine	☐ Difficulty Urinating
☐ Pain with Urination	☐ Weakness	☐ Muscle Aches	☐ Joint Aches	☐ Easy Bruising
☐ Weight Loss	☐ Stiff Neck	☐ Insomnia	☐ Pain in Skin	☐ Cataracts
☐ Vision Changes	☐ Menstrual Problems	☐ Sore Throat	☐ Night Sweats	☐ OTHER

Signature: _____ **Medical Personnel:** _____ **Date:** _____

1001 Chesterfield Pkwy East Suite #201, Chesterfield, MO 63017
Phone: (636) 532-2422 Fax: (636) 532-2425