Aesthetic Dermatology

Health History Form

Patient Name: Date:

What is the reason for your visit?

Where on your body did your problem begin?

How long have you had this skin issue?

Have you done/used anything to treat the problem?
(List any prescriptions, non-prescriptions, or remedies)

Are you allergic to any of the following?
(Check all that apply)

- ❑ Latex
- ❑ Skin Adhesives
- ❑ Local Anesthetic (specify type):
- ❑ Other Allergies/Sensitivities (Please list any known or suspected):

Preferred Pharmacy Information		
NAME OF PHARMACY	PHARMACY PHONE NUMBER	PHARMACY ADDRESS (OR GENERAL LOCATION)

List Your Medications (Prescriptions AND Over-The-Counter) *For more space, use other side of page*		
NAME OF MEDICATION	STRENGTH	FREQUENCY TAKEN
1.		
2.		
3.		
4.		
5.		

ADULT Social History / Immunization / Other Testing					
SMOKING STATUS:	ALCOHOL USE PER DAY:	FLU VACCINE	PNEUMONIA VACCINE	COLONOSCOPY IN LAST 9 YEARS	*FOR WOMEN*: MAMMOGRAM IN LAST 2 YEARS
❑ Never smoked ❑ Former smoker ❑ Current smoker: ❑ Light ❑ Heavy ❑ Tobacco User: ❑ Light ❑ Heavy	❑ 0 ❑ 1 drink ❑ 2 drinks ❑ 3 + drinks	❑ Received ❑ Declined	❑ Received ❑ Declined	❑ YES ❑ NO	❑ YES ❑ NO ❑ N/A

HEALTH HISTORY FORM CONTINUED ON NEXT PAGE

Patient's Skin History (Check All that Apply)	**Family History** List family member(s) with this SKIN condition
❑ Abnormal/ Suspicious Mole(s)	
❑ Acne/ Folliculitis/ Rosacea (Specify)	
❑ Actinic Keratosis	
❑ Cyst	
❑ Dermatitis/Eczema/Rash	
❑ Excessive Sweating	
❑ Hair Loss -Alopecia	
❑ Herpes/Cold Sores/Shingles (Specify)	
❑ Melasma	
❑ Molluscum Contagiosum	
❑ Nail Fungus	
❑ Other Skin Condition(s) (Specify)	
❑ Psoriasis	
❑ Skin Cancer (Specify)	
❑ Wart(s)	

Patient's Medical History (Check All that Apply)	**Family History** List family member(s) with this MEDICAL condition
❑ *Anemia/Other Hematologic Condition	
❑ *Anxiety/ Depression	
❑ Arthritis	
❑ Asthma	
❑ Cancer-other (Specify)	
❑ COPD/Other Respiratory Issues	
❑ Diabetes	
❑ GI Disorder (Specify)	
❑ Hearing Loss	
❑ Heart Condition/Disease (Specify)	
❑ Hepatitis/Other Liver Disease (Specify)	
❑ High Blood Pressure	
❑ High Cholesterol	
❑ HIV/AIDS	
❑ Kidney/ Other Renal Disease (Specify)	
❑ Lupus	
❑ Nerve Disorder (Specify)	
❑ Stroke / Seizures	
❑ Thyroid Disease	

Patient's Surgical History (Check All that Apply)
❑ Cosmetic
❑ Ear, Nose, and/or Throat
❑ Eye-related
❑ Female
❑ Heart/ Other Cardiac
❑ Joint Replacement/ Implants
❑ Male
❑ Organ/Bone Marrow Transplant
❑ Other Surgery
❑ Radiation/ Chemotherapy