THE DERMATOLOGY CENTER
ROCKLEDGEMEDSPA

PATIENT HEALTH HISTORY

Name (Last, First) _____ **Date of Birth** _____ ☐ **Male** ☐ **Female**

Primary Care Physician _____ **Phone** _____ **Pharmacy Name** _____ **Phone** _____

Is it ok to leave a message? ☐ **yes** ☐ **no** **Would you like to receive appointment reminder text messages?** ☐ **yes** ☐ **no**

Emergency Contact (Last, First) _____ **Phone** _____

Referring Physician _____ **Referring Friend** _____

REASON FOR VISIT

Concern: _____ **Body Part:** _____ **Duration:** _____ **Treatment:** _____

Concern: _____ **Body Part:** _____ **Duration:** _____ **Treatment:** _____

MEDICAL HISTORY

Select any of the following medical conditions that you currently have:

☐ None
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation *(Irregular Heartbeat)*
☐ Bone Marrow Transplantation
☐ Organ Transplant
☐ Bleeding problems
☐ Depression
☐ Diabetes
☐ High Blood Pressure
☐ Hepatitis
☐ HIV / AIDS
☐ Immunosuppression
☐ Kidney Disease
☐ Lupus
☐ Stroke
☐ Thyroid Disease (High/Low)

Women Only: **Pregnant** ☐ Yes ☐ No **Breastfeeding** ☐ Yes ☐ No

Cancers Other Than Skin: _____

Other Medical Problems: _____

PAST SURGERIES

Have you had any surgeries? _____

Have you had any fainting or other problems with surgery? _____

Have you had transplant surgery? _____

SKIN DISEASE HISTORY

Have you had any of the following skin conditions: ☐ None If yes, list details/date below:

☐ Basal Cell Carcinoma _____

☐ Squamous Cell Carcinoma _____

☐ Melanoma _____

☐ Other skin problems: _____

Do you wear Sunscreen? ☐ Never ☐ Daily ☐ Only when in the sun Tanning salon use? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ None If yes, which relative? _____

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PATIENT HEALTH HISTORY

MEDICATIONS

☐ No current medications

ALLERGIES

☐ No known allergies

SOCIAL HISTORY

TOBACCO USE

☐ Never ☐ Former

If current tobacco use, number of packs per day: _____ Total years smoking: _____ Tobacco Type: _____

ALCOHOL USE

☐ No alcohol Drinks per day: ☐ less than 1 ☐ I-2 ☐ 3 or more

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women?: _____

OCCUPATION: _____

IMMUNIZATIONS

Current Flu shot ☐ No ☐ Yes, Date Received: _____ Pneumonia shot ☐ No ☐ Yes, Date Received: _____

PLEASE INDICATE ANY COSMETIC INTEREST OR CONCERNS

_____ **Thanks but not interested at this time**

☐ Aging Skin
☐ Acne Scarring
☐ Scars
☐ Facial Redness
☐ Sun Damage
☐ Stretch Marks
☐ Tattoo removal
☐ Spider Veins
☐ Sagging Skin
☐ Age Spots
☐ Fat Reduction
☐ Brown Spots
☐ Hair Removal
☐ Other: _____