



HEALTH HISTORY

Patient Name: _____ DOB: _____

Past Medical History: (please check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Leukemia/Lymphoma | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis: Type A B C | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> End Stage Renal Disease (renal failure) | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Other: _____ | |

Past Surgical History: (please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Liver Transplant | <input type="checkbox"/> Melanoma Surgery |
| <input type="checkbox"/> Joint Replacement
Joint: _____ | <input type="checkbox"/> Skin Biopsy | <input type="checkbox"/> Spleen Removed |
| <input type="checkbox"/> Squamous Cell Cancer Surgery | <input type="checkbox"/> Basal Cell Cancer Surgery | <input type="checkbox"/> Kidney Transplant <input type="checkbox"/> |
| | <input type="checkbox"/> Other: _____ | |

Skin Disease History: (please check all that apply)

- | | | |
|---|--|------------------------------------|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Squamous Cell Skin Cancer | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Poison Oak | <input type="checkbox"/> Dry Skin |
| <input type="checkbox"/> Precancerous Moles | <input type="checkbox"/> Other: _____ | |

Do you wear Sunscreen? Yes ____ No ____ If yes, what SPF? _____

Do you tan in a tanning salon? Yes ____ No ____

Do you have a family history of Melanoma? Yes ____ No ____ If yes, which relative? _____

Any other family history of skin cancer or disease? _____

Drug Allergies: (please list all)

_____	_____
_____	_____
_____	_____

- | | |
|---|------------------------------------|
| Tobacco Status: ____ Use tobacco daily. | ____ Have never used tobacco. |
| ____ Use tobacco occasionally. | ____ Tobacco status unknown. |
| ____ Former tobacco user. | ____ Unknown if ever used tobacco. |

Vaccine Status: (CMS Quality of Care questions)

Age 65 and over: do you have an Advanced Care Directive? Yes ____ No ____

Age 65 and over: have you received a Pneumonia Vaccine? Yes ____ No ____ If yes, 1 or 2

Age 6 months and over: have you received a Flu Vaccine? Yes ____ No ____ Date: _____

Signature (Patient or parent/guardian)

Date