GARDEN CITY DERMATOLOGY – HEALTH HISTORY

Last Name: ________________________________ First Name: ________________________________ Age:________________

Did a healthcare provider refer you here? (M.D. ,P.A., N.P., etc) Name:_____________________________ Tel:________________

Pharmacy Name: __________________________City:_____________________________ Pharmacy Phone: ________________

Describe your current problem: ____ Height:_________ Weight:_________

How long have you had this problem?__________________________ Have you ever had it before? __________________________

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Does it: [ ] Itch [ ] Ooze [ ] Burn [ ] Bleed [ ] Other__________________________________

What are you using for it? ____

Have you recently stopped using any medications? ____

What treatment have you received in the past for this problem? ____

Have you seen another dermatologist? _____________________________________Dr.'s Name: ________________________

List of medications: ____

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____

Allergies to Medications: [ ] None ____

List all your medical problems and past surgeries:

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Did you get a flu shot? ___________________________________ Did you get a Pneumonia shot?___________________________

REVIEW OF SYSTEMS [Please check if you have a history of]:

[ ] Allergic to Latex/Rubber/Nickel/Food
[ ] Arthritis
[ ] Are You Breast Feeding
[ ] Blood/Bleeding Disorders
[ ] Cancer (Non-Skin)
[ ] Diabetes
[ ] Have a pacemaker or defibrillator?
[ ] Take antibiotics prior to surgical procedures?
[ ] Have an artificial joint or heart valve?
[ ] Heart Disease
[ ] High Blood Pressure
[ ] Immunologic Disease
[ ] Infectious Disease
[ ] Kidney Disease
[ ] Liver Disease
[ ] Form Keloids?
[ ] Are you pregnant?
[ ] Do you plan to become pregnant soon?
[ ] Lung Disease
[ ] Melanoma
[ ] Skin Cancer
[ ] Skin Disease
[ ] Thyroid Disease
[ ] Other ___________________

Please check if there is a family history of:

[ ] Acne
[ ] Actinic Keratosis
[ ] Alopecia
[ ] Arthritis
[ ] Asthma
[ ] Basal Cell Carcinoma
[ ] Breast Cancer
[ ] Colon Cancer
[ ] Cancer
[ ] Contact Dermatitis
[ ] Diabetes
[ ] Eczema
[ ] Hair Loss
[ ] Hay Fever
[ ] Hives
[ ] Lupus
[ ] Melanoma
[ ] Nail Disease
[ ] Neoplasm
[ ] Precancerous Lesions
[ ] Psoriasis
[ ] Skin Carcinoma
[ ] Squamous Cell Carcinoma

[ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Other

[ ] Do you live alone? [ ] Do you drink alcohol? [ ] Do you smoke?

Occupation: ____ Hobbies/Leisure:__________________________________

Reviewed By: ____ Date: ___________________________