Central Oregon Dermatology Health History and Review of Systems

Patient Name:_______________________________ **Date of Birth:**_________ **Today's Date:**_________

Nickname:___________________________________ **Occupation:**_______________________________________

Primary Care Provider:___________________________**Clinic Name:**_____________________________________

Are you allergic to: **Dental Anesthesia** **Yes** or **No** **Band Aid Adhesive** **Yes** or **No** **Latex** **Yes** or **No**

Do you have or have you had any of the following conditions:

******Check all that apply or Answer Yes/No******

Do you have a Pacemaker/Defibrillator? **Yes** or **NO**

Skin: **Melanoma**____what year________ **Basal Cell Carcinoma**____what year________ **Squamous Cell Carcinoma**____what year_____

Lungs: Asthma___ Emphysema___ **Depression:** Feeling Depressed/Down/Helpless/Losing interest & Pleasure____

Cardiovascular: **Artificial Heart Valve**___ Chest Pain___ Heart Attack___ High Blood Pressure___ Pacemaker___

Shortness of Breath___ Stroke___

Vaccinations: Did you get your Flu Shot this year? **Yes** or **No** Have you received a Pneumonia Shot? **Yes** or **No** (Year)___________

Other: **Artificial Joint**___ **Blood Clots**___ Cancer (*other than skin*)Type & Year____

Diabetes___ **Current** Fever/Chills___ **Current** Headache___ Hepatitis___ HIV/AIDS___ Kidney Problems____ Lupus___

Multiple Sclerosis___ **Current** Nausea/Vomiting___ Needle Phobia___ Rheumatologic____ Thyroid___ Weakness/Numbness___

Medical Conditions NOT listed ____

Family History

Are you Adopted? **Yes** or **No**

	Alive	Deceased	History of Cancers	History of Melanoma/Carcinoma	Misc. Medical Conditon
Mother					
Father					
Siblings					
Children					

Women: Are you Pregnant_____ Trying to Get Pregnant_____ Are you Breastfeeding_____

History of Sun Exposure: Did/Do you have an Outdoor Occupation____

Do you enjoy Outdoor Activities/Hobbies? **Yes** or **No** Have you experienced Multiple **Blistering Sunburns**? **Yes** or **No**

Do you wear Hats? **Yes** or **No** Do you **wear Sunscreen**? **Yes** or **No**

Have you **ever** used a Tanning Bed? **Yes** or **No** Are you **Currently** using a Tanning Bed? **Yes** or **No**

Tobacco Use:

Smoking: Never___ Previously___ Currently___ If Current **How many Cigarettes do you smoke per day**?_________________________

Chew: Never___ Previously___ Currently___ If Current **How many cans per Day**?____

Alcohol Use: Never___ Previously___ Currently___ ***If Current please circle Yes or No below***

Females-do you drink ***more than 3 drinks per week***? **Yes** or **No** **Males**- do you drink ***more than 4 per week***? **Yes** or **No**

List ALL Medications (*Both Prescriptions and Over the Counter*)____

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____

____

List ALL Allergies to Medications____

Are you interested in hearing about any of the following Treatments?

Botox ________ ***Fillers*** ________ ***Laser for Redness or Wrinkles*** ________

Have you ever had any of the treatments listed above? **Yes** or **No**

Patient Signature:_______________________________________ **Date**:_____________________________

Staff Signature:____