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** **Who is your Cardiologist?** _____

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*)_____

_____

_____

_____

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**

By signing this form I agree to allow Central Oregon Dermatology, LLC and its providers to share my information with my primary care providers, insurance companies, pharmacies, or other facilities which are deemed necessary for my medical Care. I also understand if I refuse to sign this document I may have to pay for my visits out of pocket, may not receive my prescriptions and may be unable to continue my medical treatments as recommended by Central Oregon Dermatology and its providers. I also confirm that all of my contact information and insurance information is correct and valid as of the date of my signature below.

Patient Signature:_____ **Date**:_____
Staff Signature:_____