

# Central Oregon Dermatology Health History and Review of Systems

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Nickname:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Primary Care Provider & Their Clinic Name:** \_\_\_\_\_

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

**Do you have any of the following** (circle Yes/No or check conditions that apply)

Melanoma \_\_\_ what year \_\_\_ Basal Cell Carcinoma \_\_\_ what year \_\_\_ Squamous Cell Carcinoma \_\_\_ what year \_\_\_  
 Cancer (other than skin listed above) Type & Year \_\_\_\_\_ Artificial Joint Yes or No Artificial Heart Valve Yes or No  
 Asthma \_\_\_ Blood Clots \_\_\_ Diabetes \_\_\_ Emphysema \_\_\_ Heart Attack \_\_\_ Hepatitis \_\_\_ HIV/AIDS \_\_\_ High Blood Pressure \_\_\_  
 Kidney Problems \_\_\_ Lupus \_\_\_ Multiple Sclerosis \_\_\_ Thyroid \_\_\_ Rheumatologic \_\_\_ Stroke \_\_\_ **Fear of Needles? Yes or No**

**Are you currently experiencing:** Shortness of Breath \_\_\_ Chest Pain \_\_\_ Nausea/Vomiting \_\_\_ Weakness/Numbness \_\_\_ Headache \_\_\_ Fever/Chills \_\_\_

**Do you have a Pacemaker/Defibrillator? Yes or NO** **Who is your Cardiologist?** \_\_\_\_\_

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

## Family History

Are you Adopted? Yes or No (If you don't know your family history please write N/A in space below)

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

**Women are you:** Pregnant: Yes or No Trying to Get Pregnant: Yes or No Breastfeeding: Yes or No

**Do you or have you had any of the following sun exposures:**

1. Enjoy Outdoor Activities? Yes or No
2. Experienced Blistering Sunburns? Yes or No
3. Wear Hats? Yes or No
4. Wear Sunscreen? Yes or No
5. Use Tanning Beds? Yes or No
6. Work or Worked Outdoors? Yes or No

**Tobacco Use:** **Never Smoked** \_\_\_ (If you've Never smoked please go to next section )

**Currently Smoke** \_\_\_ (If Current Please answer/circle **ALL Questions** below )

1. How often do you smoke? A) Every day B) Some days C) 2-3 times per week D) 4-5 times per week E) Daily
2. Are you interested in Quitting? A) No B) Yes C) Ready to quit
3. Once awake how soon do you smoke? A) 5 minutes B) 6-30 minutes C) 31-60 minutes D) 1 hour or more
4. How many cigarettes a day do you smoke? A) Up to 5 B) 6-10 C) 11-20 D) 21-30 E) 31 or more
5. What age did you start smoking? \_\_\_\_\_

**Formerly Smoked** \_\_\_ (if you smoked in the past Please answer/circle **ALL Questions** below)

1. When did you quit? A) less than 1 month B) 1-3 months C) 3-6 months D) 6-12 months E) 1-5 yrs F) 5-10 yrs G) 10 or more yrs
2. What age did you START smoking? \_\_\_\_\_
3. What age did you STOP smoking? \_\_\_\_\_

**How often do you consume Alcohol:** **Never** \_\_\_ **Former** \_\_\_ (if you do NOT currently drink please go to next section )

**Current** \_\_\_ (if you drink Currently Please answer/circle **ALL Questions** below )

1. How often in the last year did you drink? A) Monthly B) 2-4 drinks per month C) 2-3 drinks per week D) 4+ drinks per week
2. On a typical day how many drinks do you consume? A) 1-2 B) 3-4 C) 5-6 D) 7-9 E) 10+
3. How often In the past year on one occasion did you have 6+ drinks? A) Never B) Less than Monthly C) Monthly/weekly/Daily

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

## Drug/Medication Allergies:

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: \_\_\_\_\_