Central Oregon Dermatology Health History and Review of Systems

Patient:______________________________Date of Birth:_____________Today's Date_____________
Nickname:_________________Reason for today's visit:_______________________________________

List Allergies to Medications: ____

Do you have allergy to dental anesthesia? Yes/No Do you have a band aid allergy? Yes/No

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	Yes	No	**Other Systemic cont**:	Yes	No
Emphysema	☐	☐	Diabetes	☐	☐
Asthma/Hay fever	☐	☐	Thyroid	☐	☐
			Kidney	☐	☐
Cardiovascular:	Yes	No	Lupus	☐	☐
High Blood Pressure	☐	☐	Arthritis/muscle pain	☐	☐
Chest Pain	☐	☐	Anemia	☐	☐
Heart Attack	☐	☐	Liver Disease	☐	☐
Shortness of breath	☐	☐	Hepatitis	☐	☐
Stroke	☐	☐	HIV/AIDS	☐	☐
Fever Blisters	☐	☐	Blood Transfusion	☐	☐
Artificial joint	☐	☐			
Blood Clots	☐	☐	Cancer	☐	☐
Pacemaker	☐	☐	Rheumatologic disease	☐	☐
Artificial Heart Valve	☐	☐	Multiple Sclerosis/numbness	☐	☐
Other Systemic:	Yes	No	Recent Weight loss	☐	☐
Fever or Chills (currently)	☐	☐	Depression	☐	☐
Headache (currently)	☐	☐	Malaise (feel sick)	☐	☐

List any other diseases or conditions: ____

Recent Surgeries/Hospitalizations: ____

Skin:

Have you ever had any of the following? (Please circle)

Melanoma/Skin Cancer, If yes what type? (Basal Cell / Squamous Cell)
Unusual moles / Blistering Sunburns / Psoriasis / Eczema / Excessive Scarring / Keloids /
Other ___________________

Family History

Have any close relatives had any of the following? (Please circle): Melanoma / Skin Cancer / Unusual moles / Severe acne / Psoriasis/ Eczema

Women: ☐ Pregnant ☐ Breastfeeding ☐ Trying to get pregnant

List All Medications (prescription and non-prescriptions):

___________________ ___________________ ___________________ ___________________
___________________ ___________________ ___________________ ___________________

Do you take (circle) **Vitamin E, Aspirin, Motrin / Ibuprofen / Aleve / Coumadin / Other Blood Thinner**

What is your occupation? ____

Patient Social History:

Use of alcohol ☐ Never ☐ Social ☐ Moderate
Use of tobacco ☐ Never ☐ Previously, but quit Current packs / day ________
Use of illegal substances? ☐ No ☐ Yes **Use sunscreen**? ☐ No ☐ Yes **Wear hats**? ☐ No ☐ Yes

Patient Signature______________________Date__________Staff Signature______________________