Center for Skin Surgery & Dermatology, PLLC

Name: _____
Date of Birth: _____
Date of Service: _____

HEALTH HISTORY

AGE: _____ EYE COLOR: _____

ALLERGIES TO MEDICATIONS:_____
_____

PLEASE CHECK THE BOX IF YOU HAVE HAD A HISTORY OF THE FOLLOWING:

- ☐ **Skin cancer**
- ☐ **Pre-skin cancer**
- ☐ **Melanoma**
- ☐ **Eczema**
- ☐ **Psoriasis**
- ☐ **Keloid Scarring**
- ☐ **Cold sores/fever blister**
- ☐ **Genital warts or other STD**
- ☐ **HIV/AIDS**
- ☐ **Hepatitis B or C**
- ☐ **Difficulty healing**
- ☐ **Other skin conditions:**

_____
_____

- ☐ **Heart attack**
- ☐ **Heart disease**
- ☐ **Atrial fibrillation**
- ☐ **Chest pain**
- ☐ **High blood pressure**
- ☐ **Blood clots/ DVT or PE**
- ☐ **Vascular disease**
- ☐ **Other circulatory conditions:**

_____
_____

- ☐ **Diabetes**
- ☐ **Liver disease**
- ☐ **Kidney disease**
- ☐ **Dialysis**
- ☐ **Intestinal problems**
- ☐ **Acid reflux**
- ☐ **Internal cancers**

Type:
_____
_____

- ☐ **Stroke**
- ☐ **TIA (mini stroke)**
- ☐ **Vertigo or dizziness**
- ☐ **Seizures**
- ☐ **Migraine/chronic headaches**
- ☐ **Other neurologic disorders:**

_____
_____

- ☐ **Anxiety**
- ☐ **Depression**
- ☐ **Other mental conditions:**

_____
_____

- ☐ **Lupus**
- ☐ **Sensitivity to sunlight**
- ☐ **Other autoimmune disease:**

_____
_____

- ☐ **Glaucoma**
- ☐ **Cataracts**
- ☐ **Other ocular problems:**

_____
_____

- ☐ **Asthma**
- ☐ **COPD**
- ☐ **Other lung or breathing problems:**

_____
_____

Do you have any of the following:

Artificial joint(s)?	**Yes**	**No**	**Year(s) replaced: _____**
Artificial heart valve(s)?	**Yes**	**No**	**Year(s) replaced: _____**
Do you require antibiotics before dental or medical procedures?	**Yes**	**No**	
Pacemaker?	**Yes**	**No**	
Defibrillator?	**Yes**	**No**	
Brain stimulator?	**Yes**	**No**	
Are you currently pregnant?	**Yes**	**No**	
Do you drink alcohol?	**Yes**	**No**	**How much? _____**
Do you smoke cigarettes?	**Yes**	**No**	**How much? _____**
Do you smoke cigars?	**Yes**	**No**	**How much? _____**
Do you use vaping products?	**Yes**	**No**	
Do you use illegal drugs?	**Yes**	**No**	**Please specify: _____**
Family history of skin cancer?	**Yes**	**No**	**Please specify: _____**

When was your last flu shot?_____

Have you had the pneumonia vaccine? Yes No

Have you received your COVID vaccine? Yes No

Have you ever experienced any problems with numbing medications or injections? Yes No

If yes to above, please explain:

_____

_____

Have you ever passed out before, during or after a medical procedure? Yes No

PERFERRED PHARMACY	**TOWN**	**PHONE #**

PRESCRIPTION MEDICATIONS:

NAME	**DOSAGE (ex: 5mg)**	**ADMINISRATION (ex: oral, injection)**

NON-PRESCRIPTION OVER THE COUNTER PRODUCTS, VITAMINS AND SUPPLEMENTS

Office use only:

_____/_____Date_____	**_____/_____Date_____**
_____/_____Date_____	**_____/_____Date_____**