ROCHESTER DERMATOLOGY CLINIC
Health History Information Form

Name:_____ **Date**:_____/_____/_____

DOB:____/____/_____ ◯M◯F **Occupation:** _____ **Best Contact #**_____
(Type of work, student or retired)

Reason for your visit today:_____

Have you ever had skin cancer? ☐Yes ☐No If yes, please explain: _____

Your Personal Medical History (ROS):
Please check "Yes" or "No" to the following, as it pertains to you:

☐Yes ☐No Anxiety
☐Yes ☐No Arthritis
☐Yes ☐No Asthma
☐Yes ☐No Atrial Fibrillation
☐Yes ☐No BPH (Enlarged Prostate)
☐Yes ☐No Bone Marrow Transplantation
☐Yes ☐No Breast Cancer
☐Yes ☐No Colon Cancer
☐Yes ☐No COPD (Lung Disease)
☐Yes ☐No Coronary Artery Disease
☐Yes ☐No Depression
☐Yes ☐No Diabetes
☐Yes ☐No End Stage Renal Disease
☐Yes ☐No GERD (Acid Reflux)
☐Yes ☐No Hearing Loss
☐Yes ☐No Hepatitis
☐Yes ☐No Hypertension (High Blood Pressure)
☐Yes ☐No HIV / AIDS
☐Yes ☐No Hypercholesterolemia (High Cholesterol)
☐Yes ☐No Hyperthyroidism (Over Active Thyroid)
☐Yes ☐No Hypothyroidism (Under Active Thyroid)
☐Yes ☐No Leukemia
☐Yes ☐No Lung Cancer
☐Yes ☐No Lymphoma
☐Yes ☐No Pacemaker
☐Yes ☐No Prostate Cancer
☐Yes ☐No Radiation Treatment
☐Yes ☐No Seizures
☐Yes ☐No Stroke
☐Yes ☐No Valve Replacement

Other_____

Skin Disease History:

Please check "Yes" or "No" to the following, as it pertains to you:

☐Yes ☐No Acne
☐Yes ☐No Actinic Keratoses
☐Yes ☐No Alopecia (Hair Loss)
☐Yes ☐No Basal Cell Skin Cancer
☐Yes ☐No Blistering Sunburns
☐Yes ☐No Dry Skin
☐Yes ☐No Eczema
☐Yes ☐No Flaking or Itchy Scalp
☐Yes ☐No Hay Fever / Allergies
☐Yes ☐No Herpes Simplex (Cold Sores)
☐Yes ☐No Melanoma
☐Yes ☐No Poison Ivy
☐Yes ☐No Psoriasis
☐Yes ☐No Rosacea
☐Yes ☐No Shingles
☐Yes ☐No Squamous Cell Skin Cancer
☐Yes ☐No Warts

Other_____

Family History of Melanoma: □ Yes □ No

If Yes, which relative(s)_____

Rochester Dermatology Clinic participates with the following Pathology labs: **Pinkus, Miraca, Beaumont & Crittenton.**

If your insurance does not participate with any of the pathology labs listed above you will be responsible for the bill.

Do you need antibiotics for prophylaxis prior to procedures? □ Yes □ No

Any other major surgeries / procedures:_____

_____

Habits: Tobacco use: □ Yes □ No □ Occasional Alcohol use: □ Yes □ No □ Occasional

Have you had: Flu Vaccination □ Yes □ No Pneumonia Vaccination (65 or older) □ Yes □ No

Do you have an: Advance Care Plan (Living Will) □ Yes □ No

If yes, list surrogate decision maker_____

For Females:
Are you pregnant? □ Yes □ No Planning a pregnancy? □ Yes □ No Nursing? □ Yes □ No

Medications: RX and Over-The-Counter:
Here are the medications I am currently taking and their dosages (if known):
Medication

_____ _____ _____

_____ _____ _____

Are you taking a blood thinner? (Aspirin / Coumadin / Plavix / Fish Oil) □ Yes □ No Type: _____

Please list any allergies you have to medications / tape adhesive / Latex? *Please Specify reaction:*_____

_____

Preferred Pharmacy: _____
Name **Location (address, state, zip)** **Phone**

All the above is stated to the best of my knowledge.

X_____ _____/_____/_____
Signature (Patient, Parent, Guardian) **Date**