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	None	☐ Yes	☐ No	Human Immunodeficiency Virus Infection
☐ Yes	☐ No	Anxiety Disorder	☐ Yes	☐ No	Hypercholesterolemia
☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Hyperthyroidism
☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Hypothyroidism
☐ Yes	☐ No	Atrial Fibrillation	☐ Yes	☐ No	Inflammatory Disease of the Liver
☐ Yes	☐ No	Benign Prostatic Hyperplasia	☐ Yes	☐ No	Leukemia
☐ Yes	☐ No	Cerebrovascular Accident	☐ Yes	☐ No	Malignant Lymphoma
☐ Yes	☐ No	Chronic Obstructive Lung Disease	☐ Yes	☐ No	Malignant Tumor of Lung
☐ Yes	☐ No	Coronary Arteriosclerosis	☐ Yes	☐ No	Malignant Tumor of Breast
☐ Yes	☐ No	Depressive Disorder	☐ Yes	☐ No	Malignant Tumor of Colon
☐ Yes	☐ No	Diabetes Mellitus	☐ Yes	☐ No	Malignant Tumor of Prostate
☐ Yes	☐ No	Elevated Blood Pressure	☐ Yes	☐ No	Permanent Cardiac Pacemaker
☐ Yes	☐ No	End Stage Renal Disease	☐ Yes	☐ No	Radiation Therapy Treatment Management
☐ Yes	☐ No	Gastroesophageal Reflux Disease	☐ Yes	☐ No	Transplantation of Bone Marrow
☐ Yes	☐ No	Hearing Loss	☐ Yes	☐ No	Other

Other_____

Skin Conditions:

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

☐ Yes	☐ No	None	☐ Yes	☐ No	Herpes Simplex (Cold Sore)
☐ Yes	☐ No	Acne	☐ Yes	☐ No	Herpes Zoster (Shingles)
☐ Yes	☐ No	Actinic Keratosis (pre-cancer)	☐ Yes	☐ No	Malignant Melanoma
☐ Yes	☐ No	Alopecia (Hair Loss)	☐ Yes	☐ No	Pruritus of Scalp (Itching Scalp)
☐ Yes	☐ No	Asteatosis Cutis (Dry Skin)	☐ Yes	☐ No	Psoriasis
☐ Yes	☐ No	Basal Cell Carcinoma	☐ Yes	☐ No	Rosacea
☐ Yes	☐ No	Contact Dermatitis due to Poison Ivy	☐ Yes	☐ No	Squamous Cell Carcinoma
☐ Yes	☐ No	Dysplastic Nevus of Skin (pre-cancerous mole)	☐ Yes	☐ No	Sunburn of Second Degree
☐ Yes	☐ No	Eczema	☐ Yes	☐ No	Verruca (Wart)
☐ Yes	☐ No	H/O: Hay Fever	☐ Yes	☐ No	Other

Other_____

Family History of Melanoma: ☐ Yes ☐ No

If Yes, which relative(s)_____

Rochester Dermatology Clinic participates with the following Pathology labs: **Aurora, Corewell Health & Ascension.**
If your insurance does not participate with any of the pathology labs listed above you will be responsible for the bill.

2025 (OVER)

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

Any other major surgeries / procedures:_____

_____

Habits: Tobacco use: ☐ Yes ☐ No ☐ Occasional

Advanced 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:
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**