ESSEX DERMATOLOGY

Health History

Name: _____ **DOB:** _____ **Date:** _____

Reason for today's visit: _____

Medical History (please circle all that apply)

Anxiety	COPD	Heart Failure	Lymphoma
Arthritis	Coronary Artery Disease	Hepatitis	Prostate Cancer
Asthma	Depression	High Blood Pressure	Radiation Treatment
Atrial fibrillation	Diabetes	HIV/AIDS	Seizures
Bone Marrow transplant	End Stage Renal Disease	High Cholesterol	Stroke
BPH	GERD	Thyroid Problems (Hyper or Hypo)	Pacemaker
Breast Cancer	Hay fever / Allergies	Leukemia	**NONE**
Colon Cancer	Hearing Loss	Lung Cancer	

Other: _____

Surgeries: _____

Skin Disease History (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Precancerous Moles
Basal Cell Skin Cancer	Flaking or itchy scalp	Psoriasis
Blistering Sunburns	Melanoma	Squamous Cell Skin Cancer
NONE	Other: _____	

Medications, vitamins, herbal and dietary supplements (use back page if more space needed)

Name	Dose (if known)	How often? (Daily, twice daily, etc)

Allergies: _____ _____ _____ _____

Tobacco use (circle): Never a smoker Former Smoker Current Smoker (some days) Current Smoker (every day)

Have you gotten a flu shot / do you plan to get a flu shot?

Yes ___ No ___

If you did not / do not plan to get a flu shot, please indicate the reason below:

Allergic ___ Declined___ Vaccine Not Available _____

Melanoma Family History: Mother __ Father __ Sister __ Brother __ Daughter __ Son __ Other _____

Do you wear sunscreen? Yes____ No ____ If yes, what SPF? _____

Do you tan in a tanning salon? Yes ___ No ___

*****65 years of age and older only***** **Have you EVER received a Pneumonia vaccine?** Yes ___ No ___