PSD Health History Form

Patient Name: _____ DOB: _____

Please list all medications/dosages you are currently taking, ***including all over-the-counter, alternative medications, vitamin or herbal supplements***: _____

_____

_____

Are you allergic to any medications? ❑ Yes ❑ No / Please list: _____

Do you have any other allergies? ❑ Yes ❑ No / Please list: _____

Your Preferred Pharmacy_____ Location: _____

Check all conditions you currently have or have had in the past:

❑ Actinic keratosis	❑ Cancers	❑ Hepatitis C	❑ Phlebitis
❑ Allergies	❑ Congestive heart failure	❑ High cholesterol	❑ Psoriasis
❑ Anxiety	❑ Diabetes	❑ Hypertension	❑ Renal (kidney) disease
❑ Arthritis	❑ Depression	❑ Liver disease	❑ Rosacea
❑ Asthma	❑ Eczema	❑ Lupus	❑ Seizure disorder
❑ Atrial fibrillation	❑ Gastrointestinal disease	❑ Mental disorder	❑ Thyroid disease
❑ Blood clots	❑ Glaucoma	❑ Multiple sclerosis	❑ Tuberculosis

If you have had cancer – what type? _____

List any other diseases or conditions you may have: _____

List any surgical procedures (w/dates) you've had in the past year: _____

Family History – Please indicate if any immediate family member has/had any of the following diseases:

❑ Abnormal Moles	❑ CVA (Stroke)	❑ Keloids (bad scars)
❑ Acne	❑ Depression	❑ Lupus
❑ Allergies	❑ Dermatitis	❑ Malignant melanoma
❑ Arthritis	❑ Diabetes	❑ Psoriasis
❑ Asthma	❑ Eczema	❑ Renal (kidney) disease
❑ Basal cell carcinoma	❑ Glaucoma	❑ Rosacea
❑ Blood disease	❑ Hepatitis C	❑ Seizure disorder
❑ Coronary Artery Disease	❑ Hyperlipidemia	❑ Squamous cell carcinoma
❑ Cancer - Type? _____	❑ Hypertension	❑ Thyroid disorder
❑ COPD	❑ Inflammatory bowel disease	❑ Other _____

Skin:

Have you had skin cancer? ❑ Yes ❑ No Type/Area on body_____ Date_____

Do you have problems with healing? ❑ Yes ❑ No Do you or have you ever

Do you develop keloids (bad scars) after surgery? ❑ Yes ❑ No tanned indoors? ❑ Yes ❑ No

Social History:

What is your occupation? _____

Are you exposed to any occupational hazards? ❑ Yes ❑ No If yes, explain_____

Do you use tobacco? ❑ Yes ❑ No If yes, type? _____ / _____packs/day

Do you drink alcohol? ❑ Yes ❑ No If yes, how many drinks per day/week _____

Do you use caffeine? ❑ Yes ❑ No If yes, ❑ Coffee ❑ Tea ❑ Chocolate ❑ Other

Are there animals in your home? ❑ Yes ❑ No If yes, what type? _____

Have you traveled out of state/country recently? ❑ Yes ❑ No If yes, where? _____

Do you have or ever been exposed to HIV/AIDS? ❑ Yes ❑ No

Women:

Are you pregnant? ❑ Yes ❑ No If yes, due date: _____

Are your menstrual cycles regular? ❑ Yes ❑ No Date of last cycle _____

Reviewing Provider Signature _____ Date reviewed: _____