

PSD Health History Form

Patient Name: _____ DOB: _____

Reason for your visit today: _____ Date Symptoms Began: ____/____/____

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: _____

Your Preferred Pharmacy _____ Location: _____

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

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Actinic keratosis | <input type="checkbox"/> Cancers | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Renal (kidney) disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Lupus | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Gastrointestinal disease | <input type="checkbox"/> Mental disorder | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> 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:

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

Skin:

Have you had skin cancer? Yes No Type/Area on body _____ Date _____

Do you have problems with healing? Yes No

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

Do you develop skin rashes in reaction to: Medication Food Environment _____ 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/county 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: _____