

Drs. Ford and Rothman - Center for Cosmetic and Clinical Dermatology

Patient History Form Name: _____ DOB: _____

PRESENT PROBLEM(S): What is the purpose of your visit today? _____

PAST MEDICAL/SOCIAL HISTORY: Do you have any medical problems: Please circle and complete.

Diabetes Asthma Liver Disease Hayfever High Blood Pressure

Cancer (please specify type) _____

Do you have a pacemaker? ___No ___Yes Do you have an artificial joint? ___No ___Yes

Do you have an artificial heart valve? ___No ___Yes

MEDICATIONS: Do you take any prescription or over-the-counter medications? ___No ___Yes

Please list: _____

Are you allergic to any medications ___No ___Yes (If Yes please list) _____

FAMILY HISTORY: Are there any diseases that run in your family? ___No ___Yes (please list)

Do you or any of your blood relatives have melanoma? ___No ___Yes (relationship) _____

Do you or any of your blood relatives have skin cancer? ___No ___Yes (relationship) _____

Do you or any of your blood relatives have psoriasis? ___No ___Yes (relationship) _____

Do you or any of your blood relatives have eczema? ___No ___Yes (relationship) _____

SOCIAL HISTORY: Do you smoke? ___No ___Yes

Do you drink alcohol beverages on a regular basis? ___No ___Yes

OCCUPATION: What kind of work to you do? _____

REVIEW OF SYSTEMS:

Do you have any current or past problems with any of the following?

General Health ___No ___Yes Psychological disorder ___No ___Yes

Eyes ___No ___Yes Thyroid/Diabetes ___No ___Yes

Ears/Nose/Throat/Mouth ___No ___Yes Blood/Bleeding disorder ___No ___Yes

Heart ___No ___Yes Females: Are you pregnant? ___No ___Yes

Liver ___No ___Yes Planning to become pregnant? ___No ___Yes

Lungs ___No ___Yes Headaches/Seizures ___No ___Yes

Stomach/Bowel ___No ___Yes Kidneys ___No ___Yes

Reviewed _____

Date _____

(MD Signature)