

The Dermatology Group, HEALTH HISTORY

Welcome to the office of Drs. Groisser, Gordon, Nossa, Spates and Abbate! Good skin health requires a broad understanding of your past and present health. Please complete the following questionnaire. Thank you!

Name: _____ Birth Date: _____ Age: ____ Sex: M F Date: _____
What is the reason for your visit today: 1) _____ 2) _____
Occupation: _____

Have you had any of the following conditions in the past? Please place a check mark next to them.	Do you currently have any of the following conditions? Please place a check mark next to them.	Please check any of the following conditions which a family member (parents, children, grandparents) may have had.
skin cancer	itchiness	skin cancer
melanoma	dry skin	melanoma
atypical moles (dysplastic nevus)	oily skin	atypical moles (dysplastic nevi)
basal cell carcinoma	irritated lesions	acne
squamous cell carcinoma	changing lesions	eczema
actinic keratosis	fever	psoriasis
T-cell lymphoma	fatigue	lupus
other cancer	sweats	other cancer
diabetes	dry eyes	diabetes
sarcoid	nose bleeds	sarcoid
heart disease	swelling in hands or feet	
stroke/TIA	wheezing	
seizures/epilepsy	abdominal pain	
thyroid disease	joint pain	
lupus	headache	
hepatitis/liver disease	depression	
herpes simplex	recent weight gain	
bleeding disorder	recent weight loss	
Crohn's/colitis disease	swollen glands	
heart valve	itchy eyes	
pacemaker		
hip replacement		
cataracts		
glaucoma		
kidney/renal disease		
GYN problems		
depression		

HEALTH HABITS:
 Do you smoke? No ___ Yes ___ Quit ___
 Number of packs per day? _____
 Do you drink alcohol? Y N
 If yes, how many drinks a day?
 0-1 ___ 2 or more ___
 Do you use any illegal drugs? Y N
 If yes, which drugs? _____
 Do you spend long hours in the sun? Y N
 Have you ever had a blistering sunburn? Y N

Referring MD:		
Address/City:	Phone Number:	

CURRENT MEDICATIONS:

Name of Medication	Reason for Taking

PHARMACY INFORMATION:

Pharmacy Name:		
Address/City:	Phone Number:	

ALLERGIES:

Do you have any medication allergies? Y N If yes, please list: _____
 Do you have any other allergies? Y N If yes, please list: _____

For Females Only: Pregnant or Nursing? Y N Trying to Get Pregnant? Y N