

PATIENT HISTORY SHEET

Name _____ Birthdate _____ Age _____ Date _____

Health Plan _____ Auth visits _____ of _____

Dear Patient,

In an effort to have a more complete history for your record and to help the doctor for today's visit, please fill out the following information. Thank you.

1. Medications:

a. List all of your current medications _____

b. List all of the drugs that you are allergic to _____

c. List all of the drugs that cause side effects (i.e. Erythromycin causes stomach cramping or Codeine causes nausea and vomiting, etc.) _____

d. Are you taking any alternative medicines such as gingko biloba, garlic, or ginseng? _____

2. Review of systems: Please check yes or no for each of the following problems. If yes, please explain below.

- | | | | |
|--|--------------|----------------------------------|--------------|
| Weight loss or gain | Yes___ No___ | Diarrhea | Yes___ No___ |
| Tiredness | Yes___ No___ | Frequent urination | Yes___ No___ |
| Fever | Yes___ No___ | Skin problems | Yes___ No___ |
| Muscle pain | Yes___ No___ | Cold sores | Yes___ No___ |
| Joint pain | Yes___ No___ | Been on Accutane | Yes___ No___ |
| Heart murmur | Yes___ No___ | Abnormal scarring | Yes___ No___ |
| Seizures | Yes___ No___ | Allergy problems (i.e. hayfever) | Yes___ No___ |
| Shortness of breath | Yes___ No___ | Change in vision | Yes___ No___ |
| Arrhythmia (irregular heartbeat) | Yes___ No___ | | |
| Trouble with ears, nose, mouth or throat | Yes___ No___ | | |
| Psychiatric problems (i.e. depression, anxiety disorder, etc.) | Yes___ No___ | | |
| Endocrine problems (i.e. thyroid disorder, etc.) | Yes___ No___ | | |
| Blood problems (i.e. leukemia, anemia, etc.) | Yes___ No___ | | |

Explain _____

3. Past Medical History:

List all operations in lifetime (i.e. cancer surgery, cardiac bypass surgery, appendectomy, tonsillectomy, etc.)

List your medical illnesses: History of (i.e. high blood pressure, heart attack, high cholesterol, diabetes, tuberculosis, pneumonia, cancer, depression, etc.) _____

Have you had any sunburns in your lifetime? Yes___ No___ If yes, when? _____

Has anyone in your family had melanoma (a mole that has turned to cancer)? Yes___ No___

If yes, who? _____

Has anyone in your family had skin cancer such as basal cell cancer, squamous cell cancer? Yes___ No___

If yes, who? _____

Has anyone in your family had connective tissue disease such as lupus, rheumatoid arthritis, scleroderma, dermatomyositis?

Yes___ No___ If yes, who? _____

Has anyone in your family had asthma, hay fever, eczema? Yes___ No___ If yes, who? _____

Reviewed by Dr. Bernstein _____ Dr. Robinson _____