

COLE DERMATOLOGY & AESTHETIC CENTER, P.C.
PATIENT HISTORY FORM

Patient Name _____ Nickname _____

HISTORY OF PRESENT ILLNESS

Please describe the reason for your visit _____

Please list prior treatments for this condition _____

When was this condition first noted? _____

What areas of your face or body are involved? _____

Is the condition painful? _____ Is the condition worsening or improving? _____

PHARMACY INFORMATION

Name of Pharmacy: _____ Phone Number of Pharmacy: _____

Address of Pharmacy: _____ Zip Code of Pharmacy _____

PERSONAL HEALTH HISTORY

Marital Status _____ Race _____ Preferred Language _____

Do you smoke? NEVER/FORMER/CURRENT EVERY DAY/CURRENT SOME DAYS {circle one}

FEMALE MENSTRUAL HISTORY

Last Menstrual Period _____ Are you pregnant? _____ Are you trying to get pregnant? _____

Are you sexually active? _____ What type of contraception are you using? _____

Age at menopause? _____ Number of Children _____

ALLERGIES TO MEDICATIONS Please list ALL medications you are allergic to: _____

MEDICATIONS: Please list ALL medications you take or use including prescriptions and over the counter pills and creams: _____

SKIN CANCER HISTORY

Personal History of Skin Cancer? YES/NO If yes provide type of skin cancer: BASAL CELL CARCINOMA/SQUAMOUS CELL CARCINOMA/MELANOMA

Family History of Skin Cancer? YES/NO If yes provide type of skin cancer: BASAL CELL CARCINOMA/SQUAMOUS CELL CARCINOMA/MELANOMA

SKIN DISEASE HISTORY

ECZEMA: Personal history of eczema? YES/NO Childhood eczema? YES/NO

Asthma? YES/NO Allergic rhinitis/conjunctivitis (hayfever)? YES/NO

Family history of eczema? YES/NO

PSORIASIS: Personal history of psoriasis? YES/NO Personal History of psoriatic arthritis? YES/NO

Family history of psoriasis? YES/NO Personal History of nail problems? YES/NO

SKIN TYPE AND SKIN CANCER RISK FACTORS:

Eye color: _____ Hair color: _____ Ethnic origin: _____

Sunburn easily? NO/YES Tan easily? NO/YES History of abnormal moles? NO/YES

Freckling of upper back? NO/YES More than 3 blistering sunburns as a child? NO/YES

Numerous moles? NO/YES Outdoor job: NO/YES Tanning bed use: NO/YES

SOCIAL HISTORY

Occupation _____ Drink alcohol? YES/NO Amount/frequency _____
Illegal Drug Use: YES/NO HIV+: YES/NO
Depression: YES/NO Suicide Attempt: YES/NO

PAST MEDICAL HISTORY Please indicate "X" if you have ever had any of these conditions:

Cardiovascular: ___ Artificial Joints/Valves ___ Blood Clot ___ High Blood Pressure (Hypertension)
___ High Cholesterol (Hypercholesterolemia) ___ Heart Disease ___ Pacemaker ___ Stroke

Childhood Disease: ___ Chicken Pox

Dermatological: ___ Accutane ___ Atopic Dermatitis ___ Fillers (injected ___ Genital Warts (HPV)
___ Fever Blisters ___ Herpes- Oral ___ Herpes- Genital ___ Psoriasis ___ Shingles

Endocrine: ___ Diabetes Type I ___ Diabetes Type II ___ Hormone Problems ___ Thyroid Disease

Gastrointestinal: ___ Hepatitis ___ Inflammatory Bowel Disease ___ Liver Disease ___ Ulcer

Genitourinary: Female: ___ Abnormal Pap Smear ___ Infertility ___ Miscarriage

Male: ___ Prostate

Renal/ Kidney: ___ Dialysis ___ Kidney Disease

Head, Eyes, Ears, Nose, Throat: ___ Cataracts ___ Dentures ___ Glaucoma ___ TMJ Disease

Hematologic/ Lymphatic: ___ Anemia (Low Blood Count) ___ Bleeding Disorder
___ Cancer (Type) _____

Immunologic: ___ HIV ___ Auto-Immune Disease ___ Epstein-Barr ___ Lupus ___ Sarcoid

Musculoskeletal: ___ Arthritis ___ Metal Implants ___ Osteoporosis

Neurological: ___ Migraine Headaches ___ Neurological Disease ___ Seizures ___ Stroke

Psychiatric: ___ ADHD ___ Alcoholism ___ Anxiety ___ Body Dysmorphic Disorder ___ Depression
___ Drug Addition ___ Learning Disability ___ Mental Retardation ___ OCD ___ Panic Attacks
___ Schizophrenia

Respiratory: ___ Asthma ___ Hay Fever ___ Respiratory Disease ___ Tuberculosis

FAMILY HISTORY

RELATION	AGE	DISEASE	AGE AT DEATH	CAUSE OF DEATH

SURGICAL HISTORY

TYPE OF SURGERY AND OUTCOME	YEAR

REVIEW OF SYSTEMS: If you are CURRENTLY experiencing symptoms, please list:

CONSTITUTIONAL

- Fatigue
- Fever
- Weight gain
- Weight loss

EYES

- Blurred vision
- Eye pain L/R
- Eye dryness L/R

EARS

- Ear pain L/R
- Hearing loss L/R

NOSE/MOUTH/THROAT

- Bleeding from nose
- Mouth lesions
- Swollen glands

CARDIOVASCULAR

- Chest pain

RESPIRATORY

- Cough

GASTROINTESTINAL

- Abdominal pain
- Diarrhea
- Nausea

GENITOURINARY

- Irregular periods

MUSCULOSKELETAL

- Joint swelling
- Joint tenderness
- Joint stiffness
- _____ List joints

SKIN CHANGES

- Rash
- Lumps
- Changing moles
- Nail changes

BREAST

- Breast skin changes

NEUROLOGICAL

- Fainting
- Headaches
- Numbness
- Weakness

PSYCHIATRIC

- Anxiety
- Depression
- Suicidal thoughts

HEME/LYMPHATIC

- Easy bleeding
- Easy bruising
- Swollen glands

ALLERGIC/IMMUNE

- Runny nose
- Hives
- Infection

ENDOCRINE

- Excessive thirst
- Cold intolerance
- Heat intolerance
- Energy level decreased
- Energy level increased
- Weight gain
- Weight loss

Please follow up with your primary care physician to address any general medical issues which were mentioned above.