AV DERMATOLOGY ph. (661) 949-0004 fax. (661) 949-5286

HEALTH HISTORY

Name: _____ Date of Birth: _____

Have you ever had any of the following? (Check all that apply and explain as needed)

☐ Skin cancer _____
cancer type *location* *date of tratment*

☐ Hepatitis or blood transfusions _____
list dates

☐ Surgery _____
list with dates

☐ Asthma
☐ Eczema or skin rashes
☐ Glaucoma
☐ High blood pressure
☐ Heart or kidney disease
☐ Peptic ulser
☐ Psoriasis
☐ Migraine headaches
☐ Diabetes
☐ Tuberculosis

☐ Other medical problems _____
list

Have any of your relatives ever had any of the following? (Check all that apply and explain as needed)

☐ Psoriasis
☐ Skin cancer, melanoma
☐ Other skin problems
☐ Eczema/Rashes
☐ Asthma/Hay fever
☐ Migraine Headaches

Are you allergic to any medications, foods, pollens, dust, animals, etc. (Please list with symptoms caused)

_____

Are you currently on any medications? (list)_____

Females (Check all that apply)

☐ Are you pregnant?
☐ Are you nursing an infant?
☐ Do you take birth control pills?
☐ Name of birth control pill _____
☐ Date of last menstrual period _____/_____/_____

Referring Physician: Name: _____ Phone: ( )_____

Address: _____

_____

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____