PETERSON DERMATOLOGY

Dermatology Health History

Welcome to the office of Dr. Peterson! 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**

What is the reason for your visit today: 1)_____

Referred by: _____

Please circle any of the following conditions that you have been diagnosed with.	Do you currently have any of the following conditions? Please circle any that apply.	Please circle any of the following conditions which a family member (parents, children, siblings, grandparents) may have had.
Actinic Keratosis	Abdominal Pain	Acne
Anxiety	Blood in Stool	Atypical Moles
Artificial Heart Valve	Changing Lesions	Diabetes
Asthma	Chest Pain	Eczema
Atypical Moles	Cough	Lupus
Bleeding Disorder/Anemia	Depression/Anxiety	Psoriasis
Cancer: Type_____	Dry eyes/ itchy eyes	Melanoma
COPD/Emphysema	Dry skin	Sarcoid
Crohn's/ Colitis	Fatigue	Skin Cancer
Depression	Fever	
Diabetes	Headache	**Health Habits:**
Eczema	Irritated Lesions	Do you smoke: Y N Quit
Elevated Chol./ Triglyceride	Itchiness	Number of packs per day_____
Gynecologic Problems	Joint Pain	Do you drink alcohol? Y N
Hay fever	Nose Bleeds	If yes, number of drinks per day?
Heart Disease	Oily Skin	0-1_____ 2 or more _____
Hepatitis/ Liver Disease	Recent weight changes: Gain Loss	Do you use Illegal drugs? Y N
Herpes Simplex	Shortness of Breath	If yes, which drugs _____
HIV/ AIDS	Sweats	Do you spend long hours in the sun? Y N
Hip/Knee Replacement	Swelling: Hands Feet	Ever had blistering sun burn? Y N
Hypertension (high BP)	Swollen Glands	Do you use indoor tanning bed? Y N
Kidney/ Renal Disease	Wheezing	Do you drive during the day? Y N
Lupus		Do you drive at night? Y N
Melanoma	**Surgical History**	Do you exercise? Y N
Pacemaker/ Defibrillator	_____	If yes, how often? _____
Psoriasis	_____	Caffeine use? Y N
Seizure/ Epilepsy	_____	If yes, how often? _____
Skin Cancer	_____	**Medication Allergies:**_____
Stroke/ TIA	_____	_____
Thyroid Disorder	_____	_____
		_____

Current medications: _____

_____

_____

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

Females only: Pregnant or Nursing? Y N Trying to get pregnant? Y N