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COMPLETE HEALTH HISTORY FORM

Patient: _____ Date of Birth: ___/___/___ Today's Date: ___/___/___

Retail or Mail-order Pharmacy Information:_____
Name Location Phone
Primary Care Physician:_____
Name Location Phone
Referring Physician:_____
Name Location Phone
Reason for Today's Visit:_____

Surgical History:_____
Currently Pregnant: ☐ Yes ☐ No Due Date: ___/___/___ Currently Breast Feeding: ☐ Yes ☐ No
Are you planning a pregnancy in the next year: ☐ Yes ☐ No
Are you allergic to any medications? ☐ YES ☐ NO If yes, please list:_____
Have you ever had Dental Anesthesia(Lidocaine/Epinephrine)? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO
Healing Problems: ☐ YES ☐ NO

List all medications you are currently taking (include current dose):

_____

_____

Personal/Past Medical History: SELECT ALL THAT APPLY Height_____ Weight_____
History of: Cancer and/or on current method of treatment: _____

_____

Social History: SELECT ALL THAT APPLY

Do you drink alcohol? ☐ YES ☐ NO If YES _____ drinks per day
Do you use recreational drugs? ☐ YES ☐ NO If YES, what & how often:_____
Smoking Status: ☐Current everyday ☐Current some day's ☐Former ☐Never ☐Unknown if ever smoked
Type: ☐Smokeless ☐ Cigars ☐ Cigarettes ☐ Marijuana
For how long:_____
Do you use a tanning bed? ☐ YES ☐ NO Frequency:_____
Do you tan outside? ☐ YES ☐ NO Frequency:_____
Do you use sunscreen? ☐YES ☐ NO

Family History: SELECT ALL THAT APPLY

☐ Basal Cell ☐ Squamous Cell ☐ Melanoma ☐ Skin Cancer (unknown type)
☐ Acne Psoriasis ☐ Hair Loss ☐ Several Moles ☐ Skin Rashes
Please list any other significant Family Medical History:_____

Review of Systems: SELECT ALL THAT APPLY

Natural/Original Hair Color: ☐ Black ☐ Brown ☐ Light Brown ☐ Red ☐ Blonde

Natural Eye Color: ☐ Black ☐ Hazel ☐ Gray ☐ Green ☐ Brown ☐ Blue ☐ Red ☐ Light Brown

Skin Color: ☐ Very Pale ☐ Fair ☐ Med-Olive ☐ Dark ☐ Olive Brown ☐ Black

INFECTIOUS

Tuberculosis ☐ Yes ☐ No
HIV/Aids ☐ Yes ☐ No
Hepatitis B or C ☐ Yes ☐ No
Herpes ☐ Yes ☐ No

GYNECOLOGY

Irregular Menstrual Cycle ☐ Yes ☐ No
Menopause ☐ Yes ☐ No
Pregnancy ☐ Yes ☐ No
Miscarriages ☐ Yes ☐ No

MUSCULOSKELETAL

Artificial Joints ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No
Gout ☐ Yes ☐ No
Lupus ☐ Yes ☐ No

UROLOGY

Kidney Disease ☐ Yes ☐ No
Dialysis ☐ Yes ☐ No

RESPIRATORY

Asthma ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No
Sacoidosis ☐ Yes ☐ No

Abnormal Chest X-Ray ☐ Yes ☐ No
Seasonal Allergies ☐ Yes ☐ No

CARDIOLOGY

Heart Murmur ☐ Yes ☐ No
Heart Valve ☐ Yes ☐ No
Pacemaker ☐ Yes ☐ No
High/Low Blood Pressure ☐ Yes ☐ No
Varicose Veins ☐ Yes ☐ No
Artery Disease ☐ Yes ☐ No
Stent/Bypass ☐ Yes ☐ No

HEMATOLOGY

Anemia ☐ Yes ☐ No
Blood Clots ☐ Yes ☐ No
Lymphoma ☐ Yes ☐ No
Leukemia ☐ Yes ☐ No

Sickle Cell Anemia ☐ Yes ☐ No
Low WBC Dialysis ☐ Yes ☐ No
Excessive Bleeding ☐ Yes ☐ No

GASTROENTEROLOGY

Stomach Ulcers ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
Crohn's Disease ☐ Yes ☐ No

PSYCHOLOGY

Depression ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Bulimia/Anorexia ☐ Yes ☐ No
Chemical Dependency ☐ Yes ☐ No

EYES, EARS, NOSE & THROAT

Dry Mouth ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Sinus Infections ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No

ENDOCRINOLOGY

Diabetes ☐ Yes ☐ No
Thyroid Disease ☐ Yes ☐ No

NEUROLOGY

Seizures ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Multiple Sclerosis ☐ Yes ☐ No

DERMATOLOGY

Acne ☐ Yes ☐ No
Eczema ☐ Yes ☐ No
Psoriasis ☐ Yes ☐ No

Nail Problems ☐ Yes ☐ No
Hair Loss ☐ Yes ☐ No
Sun Sensitivity ☐ Yes ☐ No
Reaction to Jewelry ☐ Yes ☐ No
Rosacea ☐ Yes ☐ No
Scars/Keloids ☐ Yes ☐ No
Cold Sores ☐ Yes ☐ No
Warts ☐ Yes ☐ No
Genital Warts ☐ Yes ☐ No

List CURRENT Symptoms:

SKIN

Changing Moles ☐ Yes ☐ No
Itching ☐ Yes ☐ No
Burning ☐ Yes ☐ No
Welts ☐ Yes ☐ No
Hives ☐ Yes ☐ No
Sores ☐ Yes ☐ No

GENITOURINARY

Abnormal Urination ☐ Yes ☐ No
Genital Discharge ☐ Yes ☐ No
Menstrual Irregularities ☐ Yes ☐ No

HEMATOLOGIC

Bruise easily ☐ Yes ☐ No
Blood Clots ☐ Yes ☐ No

CONSTITUTIONAL
Fever ☐ Yes ☐ No
Night sweats ☐ Yes ☐ No
Chills ☐ Yes ☐ No
Weight changes ☐ Yes ☐ No

EAR NOSE THROAT
Sores ☐ Yes ☐ No
Growths ☐ Yes ☐ No
Sinus Problems ☐ Yes ☐ No
Difficulty Swallowing ☐ Yes ☐ No

GASTROINTESTINAL
Abdominal pain ☐ Yes ☐ No
Diarrhea ☐ Yes ☐ No

MUSCULOSKELETAL
Joint pain ☐ Yes ☐ No
Swelling ☐ Yes ☐ No
Muscle pain/weakness ☐ Yes ☐ No

NEUROLOGIC
Weakness ☐ Yes ☐ No
Numbness ☐ Yes ☐ No
Headaches ☐ Yes ☐ No

RESPIRATORY
Shortness of breath ☐ Yes ☐ No
Wheezing ☐ Yes ☐ No
Cough ☐ Yes ☐ No

ENDOCRINE
Cold/Heat intolerance ☐ Yes ☐ No

OTHER: _____

Authorization for telephone communication: Choose one of the following

____I authorize Tatyana Melnik, ARNP to leave a message of non-sensitive nature that may contain protected health care information on my voicemail or answering machine. Phone number:

____I authorize Tatyana Melnik, ARNP to leave a message or communicate details of my Dermatology care that may contain protected health care information with:

LAST, FIRST	RELATIONSHIP	PHONE

____I **do not** authorize Tatyana Melnik, ARNP to leave a message containing protected health care information

PRINT PATIENT NAME	PATIENT OR AUTHORIZED LEGAL SIGNATURE	RELATIONSHIP TO PATIENT	DATE
			___/___/___