HEALTH HISTORY FORM – SKINCARE PHYSICIANS OF FAIRFIELD COUNTY Today's Date: ___ / ___ / ___

Name: _____ Date of Birth: ___ / ___ / ___

Occupation: _____ Do you work with: ☐ Plants/Outdoors ☐ Chemicals/Irritants

ALLERGIES

List allergies to medication/food/environment: _____ _____ _____

_____ _____ _____

Do you have an allergy to **dental anesthesia**? ☐ Yes ☐ No Do you have an **adhesive/band aid** allergy? ☐ Yes ☐ No

MEDICATIONS

Do you take any of the following medications daily (circle):

Vitamin E /Aspirin /Motrin / Ibuprofen / Aleve / Coumadin / Other Blood Thinner / Birth Control (pills / patch / IUD)

List Medications (*prescription, non-prescription, supplements AND/OR ointments/lotions/creams used regularly*):

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

PERSONAL HEALTH HISTORY & REVIEW OF SYSTEMS

Do you have now, or have you ever had (check YES or NO or provide more info if necessary):

Lungs:	Yes	No	Staff Use	*Other/Systemic:*	Yes	No	Specify	Staff Use
Asthma/Hay Fever	☐	☐	_____	Diabetes (Specify)	☐	☐	_____	_____
Emphysema/COPD	☐	☐	_____	Thyroid (Specify)	☐	☐	_____	_____
Cardiovascular:				Kidney	☐	☐	_____	_____
Anemia	☐	☐	_____	Unusual Rashes	☐	☐	_____	_____
Artificial Heart Valve	☐	☐	_____	Recurrent Fevers	☐	☐	_____	_____
Artificial Joint	☐	☐	_____	Cancer (specify)	☐	☐	_____	_____
Blood Clots	☐	☐	_____	Rheumatologic (Specify)	☐	☐	_____	_____
Chest Pain	☐	☐	_____	Arthritis/muscle pain	☐	☐	_____	_____
Fever Blisters	☐	☐	_____	HIV/AIDS/ Hepatitis C	☐	☐	_____	_____
Heart Attack	☐	☐	_____	Weight Gain/Loss	☐	☐	_____	_____
High Blood Pressure	☐	☐	_____	Lupus	☐	☐	_____	_____
Pacemaker or Stent	☐	☐	_____	Neurologic (Specify)	☐	☐	_____	_____
Shortness of Breath	☐	☐	_____	Liver Disease	☐	☐	_____	_____
Stroke	☐	☐	_____					
Skin/Hair/Nails				*Social*				
Basal Cell Skin Cancer	☐	☐	_____	Anxiety	☐	☐	_____	_____
Melanoma/Skin Cancer	☐	☐	_____	Depression	☐	☐	_____	_____
Squamous Cell Cancer	☐	☐	_____	Tobacco Use	☐ Never	☐ Formerly	☐ Socially	☐ Often
Psoriasis	☐	☐	_____	Alcohol Use	☐ Never	☐ Formerly	☐ Socially	☐ Often
Eczema	☐	☐	_____	Drug Use	☐ Never	☐ Formerly	☐ Socially	☐ Often
Hair loss	☐	☐	_____					

Other Conditions/Disorders: _____

Surgeries/Hospitalizations: _____

Patient/Guardian Signature _____ **Staff Initials:** _____

HEALTH HISTORY FORM – SKINCARE PHYSICIANS OF FAIRFIELD COUNTY (Continued)

Name: _____ Date of Birth: ___ / ___ / ___

FAMILY HEALTH HISTORY

Have ANY close relatives had any of the following (check all that apply, specify as necessary):

Skin-related Problems	Mother	Father	Siblings	Grandparents	Specify/Describe
Basal Cell Carcinoma	☐	☐	☐	☐	_____
Melanoma/Skin Cancer	☐	☐	☐	☐	_____
Squamous Cell Carcinoma	☐	☐	☐	☐	_____
Acne	☐	☐	☐	☐	_____
Asthma	☐	☐	☐	☐	_____
Eczema/Atopic Dermatitis	☐	☐	☐	☐	_____
Gluten or Lactose Intolerance	☐	☐	☐	☐	_____
Hair loss/Alopecia	☐	☐	☐	☐	_____
Psoriasis	☐	☐	☐	☐	_____
Rosacea	☐	☐	☐	☐	_____
Sinus Problems/Hay Fever	☐	☐	☐	☐	_____
Other Skin Problems	☐	☐	☐	☐	_____
Other Health Conditions	**Mother**	**Father**	**Siblings**	**Grandparents**	**Specify/Describe**
Arthritis/Bone or Joint Problems	☐	☐	☐	☐	_____
Bleeding or Blood Problems	☐	☐	☐	☐	_____
Blood Pressure Problems	☐	☐	☐	☐	_____
Chronic Bronchitis/Emphysema	☐	☐	☐	☐	_____
Emotional Problems	☐	☐	☐	☐	_____
Eye or Ear Problems	☐	☐	☐	☐	_____
Heart Attack/Heart Failure	☐	☐	☐	☐	_____
Heart Rhythm Problems	☐	☐	☐	☐	_____
Kidney	☐	☐	☐	☐	_____
Liver Problems/Hepatitis	☐	☐	☐	☐	_____
Headaches/Migraines	☐	☐	☐	☐	_____
Seizures/Convulsions	☐	☐	☐	☐	_____
Stomach Or Bowel Problems	☐	☐	☐	☐	_____
Thyroid Gland Problems	☐	☐	☐	☐	_____
Other Health Problems	☐	☐	☐	☐	_____

Patient/Guardian Signature _____ **Date:** ___ / ___ / ___

Staff Signature: _____