David F. Young MD, PC
DERMATOLOGY

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HEALTH HISTORY

Patient Name: _____ DOB: _____

Past Medical History: (please check all that apply)

☐ Depression
☐ Diabetes
☐ End Stage Renal Disease (renal failure)
☐ Thyroid Disease
☐ Leukemia/Lymphoma
☐ Hepatitis: Type A B C
☐ HIV/Aids
☐ History of Cancer
☐ Asthma, Hay Fever
☐ Hypertension
☐ Radiation Treatment
☐ Blood Thinners

Other: _____

Past Surgical History: (please check all that apply)

☐ Heart Transplant
☐ Joint Replacement
Joint: _____
☐ Liver Transplant
☐ Kidney Transplant
☐ Spleen Removal
☐ Other: _____
☐ Are you scheduled for surgery in the next 2 months _____
☐ Pacemaker Placement
☐ Valve Replacement

Skin Disease History: (please check all that apply)

☐ Basal Cell Skin Cancer
☐ Squamous Cell Cancer
☐ Melanoma
☐ Actinic Keratoses
☐ Abnormal Moles
☐ Eczema
☐ Flaking or Itchy Scalp
☐ Blistering Sunburns
☐ Allergic Skin Reaction
☐ Other: _____
☐ Psoriasis
☐ Rosacea
☐ Acne
☐ Dry Skin

Do you wear Sunscreen? Yes _____ No_____ If yes, what SPF? _____
Have you ever used a tanning salon? Yes _____ No_____
Do you have a family history of Melanoma? Yes _____ No_____ If yes, which relative?_____
Any other family history of skin cancer or disease? _____

Drug Allergies: (please list all)

_____ _____
_____ _____
_____ _____

Tobacco Status:
_____ Use tobacco daily.
_____ Use tobacco occasionally.
_____ Former tobacco user.
_____ Have never used tobacco.
_____ Tobacco status unknown.
_____ Unknown if ever used tobacco.

Vaccine Status: (CMS Quality of Care questions)
Age 65 and over: do you have an Advanced Care Directive? Yes _____ No_____ If yes, designee name:_____

_____
Signature (Patient or parent/guardian) Date

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