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)
- ☐ Hyperthyroidism
- ☐ Leukemia/Lymphoma
- ☐ Hepatitis: Type A B C
- ☐ HIV/Aids
- ☐ Other: _____
- ☐ Hypothyroidism
- ☐ Hypertension
- ☐ Radiation Treatment

Past Surgical History: (please check all that apply)

- ☐ Heart Transplant
- ☐ Joint Replacement
  Joint: _____
- ☐ Squamous Cell Cancer Surgery
- ☐ Liver Transplant
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Other: _____
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Kidney Transplant

Skin Disease History: (please check all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Precancerous Moles
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Squamous Cell Skin Cancer
- ☐ Poison Oak
- ☐ Other: _____
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Melanoma
- ☐ Dry Skin

Do you wear Sunscreen? Yes _____ No_____ If yes, what SPF? _____

Do you tan in 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_____

Age 65 and over: have you received a Pneumonia Vaccine? Yes _____ No_____ If yes, 1 or 2

Age 6 months and over: have you received a Flu Vaccine? Yes _____ No_____ Date: _____

_____

Signature (Patient or parent/guardian) Date

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