BEND DERMATOLOGY CLINIC

History Form

Patient Name: _____ **Date of Birth:** _____

Preferred Pharmacy

Name: _____

Phone Number: _____ City or Zip Code: _____

Past Medical History (check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ Benign Prostatic Hyperplasia
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____

_____

Women Only:

Date of last gynecologic exam:

_____

Currently on birth control:

◯ Yes ◯ No

Currently pregnant:

◯ Yes ◯ No

Past Surgical History (past 1 year)

_____

_____

Skin Disease History (check all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Poison Ivy
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ NONE
- ☐ Other

_____

_____

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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?

_____

_____

Medications

List all current medications:

_____

_____

_____

Allergies

List all allergies and reactions if known:

_____

_____

Social History (check all that apply)

Smoking Status (please choose one):

- Current everyday smoker
- Current someday smoker
- Former smoker
- Never smoker
- Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Alcohol Intake (please choose one):

- None
- 1 or less per day
- 1-2 per day
- 3 or more per day

Pneumonia Vaccination Received?

Yes No

Influenza Vaccination Received?

Yes No

Height: _____ **Weight:** _____

Family History

- Acne
- Allergies / Hay fever / Asthma
- Eczema
- Heart Disease
- Lung Disease
- Tuberculosis
- Other

_____