HEALTH HISTORY FORM
CENTER OF DERMATOLOGY, PC

NAME: «PatientFullName» **DOB: «PatientDOB»** **DATE: «CurrentDate»**
ACCT#: «AccountNumber» **PATIENT #: «PatientNumber»**

Reason for Visit: _____

Current Medications: __NO ___YES List Meds:_____

_____

List any street or illicit drugs:_____

List any nonprescription drugs, herbals, or vitamins you take:_____

_____

__NO ___YES Allergies to any medications: List:_____

List previous hospitalizations/surgeries: _____

Illnesses:_____

DO YOU HAVE ANY PROBLEMS WITH THE FOLLOWING BODY FUNCTIONS OR CONDITIONS? (IF YES PLEASE EXPLAIN)
___NO ___YES If female are you *PREGNANT* or *NURSING*? (circle one if yes)

___NO ___YES Eyes: _____

___NO ___YES Ears, Nose, Throat:_____

___NO ___YES Thyroid: _____

___NO ___YES Heart or Lungs:_____

___NO ___YES Stomach or Bowels: _____

___NO ___YES Liver, Hepatitis or HIV: _____

___NO ___YES Kidney, Urinary or Genitalia: _____

___NO ___YES Muscles or Joints:_____

___NO ___YES Neurologic or Psychiatric: _____

___NO ___YES Skin: _____**In the sun? ___ Tan ___ Burn ___Both**

___NO ____YES Family History Skin Cancer or Skin Disease? _____

___NO ___YES Alcohol use? If yes how many drinks a week?_____

___NO ___YES Have you ever Smoked? Do you smoke now? ____NO ___YES If yes how much?_____

___NO ___YES Cancer? What type and when?_____

Would you like Dr. Stoller to communicate with your personal or referring physician? _____YES _____NO
If yes, please list your personal or referring physician below. By listing the name(s) and signing below you give your permission for Dr. Stoller to communicate with them for purposes of your medical care. **PLEASE NOTIFY OUR STAFF IF YOUR BLOODWORK OR PATHOLOGY SPECIMENS REQUIRE A SPECIFIC LABORATORY FOR TESTING.**

Your physician: _____

_____ _____
Signature **Date**

_____ _____
Herschel E Stoller, MD (initials serve as signature) **Date**