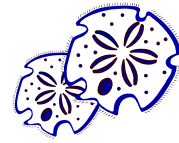




BLUEWATER BAY DERMATOLOGY AND SKIN SURGERY CENTER



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Personal History Form

Last Name: _____ **First Name:** _____ **Date:** _____

Home Phone: _____ **Pharmacy:** _____ **Sex:** () Male () Female

Work Phone: _____ **Pharmacy Phone:** _____ **Date of Birth:** ____ - ____ - ____

Height: _____ **Weight:** _____

Allergies to Medications:

None

1. _____

Reaction: _____

Current Medications

None

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Aspirin/Motrin/Advil

Yes No

Birth Control Pills

Yes No

Are you pregnant

Yes No

Coumadin

Yes No

Are you breast feeding

Yes No

Plan on becoming pregnant

Yes No

Review of Systems Screen *(Current or past problems with)*

	Yes	No		Yes	No		Yes	No
Blood/Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (sugar)	<input type="checkbox"/>	<input type="checkbox"/>	Immunologic Disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Latex/Rubber/Nickel/Food	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease or Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Disease (TB, HIV)	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Received Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Melanoma	<input type="checkbox"/>	<input type="checkbox"/>

Do you:

Have a pacemaker or defibrillator

Yes No

Take antibiotics prior to surgical procedures

Have an artificial joint or heart valve

Yes No

Form Keloids

List surgeries:

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Family History *(Check the following medical conditions which have occurred in your family)*

Disease	Mother	Father	Blood Relative	None	Disease	Mother	Father	Blood Relative	None
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History

Do you live alone?

Yes No

Do you drink alcohol?

Yes No

Frequency _____

Do you use recreational drugs?

Yes No

Frequency _____

Occupation _____

Hobbies/Leisure activity _____

Patient Signature: _____

Date: _____