HARRIS DERMATOLOGY

Medical History

Patient: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? ❑ YES ❑ NO If YES, list: _____

List all Medications with dosage you are currently taking including over the counter medications, vitamins and supplements:

❑ None ❑ Not Available ❑ See List

_____

_____

LUNGS:	YES	NO
Emphysema	❑	❑
Asthma	❑	❑
O_2 Dependent/Use	❑	❑
VASCULAR:		
High Blood Pressure	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Pacemaker	❑	❑
Defibrillator	❑	❑
Phlebitis	❑	❑
Mitral Valve Prolapse	❑	❑
Heart Valve Replacement	❑	❑

Other, Systemic:	YES	NO
Diabetes	❑	❑
Dialysis (Past or present)	❑	❑
Kidney _____	❑	❑
Thyroid _____	❑	❑
Bladder _____	❑	❑
Stomach _____	❑	❑
Bowel _____	❑	❑
Hepatitis	❑	❑
Glaucoma	❑	❑
Arthritis/Joint Deformity	❑	❑
Convulsions, Epilepsy, or Seizures	❑	❑
Fainting	❑	❑
Cold Sores/Fever Blisters/Herpes Simplex Virus	❑	❑
If Yes, Frequency _____		

List any other disease or condition we should know about including malignancies/cancer: _____

_____

List surgical procedures you have had in the last 6 months: _____

Have you been told you need to take antibiotics before routine dental cleanings or surgical procedures? ❑ Yes ❑ No

If yes, what do you take and why? _____

Who is your Primary Care Physician: _____ Pharmacy of Choice: _____

Did a physician refer you to our practice? ❑ Yes ❑ No If yes, whom? _____

Do you see any specialist? ❑ Oncologist ❑ Allergist ❑ Cardiologist ❑ Nephrologist

❑ Rheumatologist ❑ Orthopedic Surgeon ❑ Other: _____

Skin: When you are exposed to sun do you: ❑ Tan only ❑ Tan and burn ❑ Burn

Have you ever had skin cancer? ❑ Yes ❑ No

Has anyone in your family had skin cancer? ❑ Yes ❑ No If YES, Who? _____

Do you have a history of any specific skin diseases? ❑ Yes ❑ No

If yes, please list: _____

Please answer the following questions:

A. Tobacco use: ❑ Current Smoker (how much)_____ ❑ Former Smoker (when quit)_____ ❑ Never Smoker

B. Do you drink alcohol? ❑ Yes ❑ No If Yes, _____ drinks per day

C. Do you bleed easily? ❑ Yes ❑ No

D. Do you have artificial joint(s) ❑ Yes ❑ No If Yes, which joint _____ When _____

E. (Women) Are you pregnant? ❑ Yes ❑ No

F. (Women) Are you breast feeding? ❑ Yes ❑ No

G. What is your occupation? _____

H. What are your hobbies? _____

Completed by: ❑ Patient

❑ Caregiver _____ Initials

❑ Medical Assistant

_____

Signed by Physician Date

_____

Reviewed by Date

HD CL 010 10/14 Chart # _____

HARRIS DERMATOLOGY

Additional Medical History

Patient: _____ Date: _____

Have you had the Flu Vaccine? ❑ Yes ❑ No If yes, when: _____

Have you had the Pneumonia Vaccine? ❑ Yes ❑ No If yes, when: _____

Do you have Diabetes? ❑ Yes ❑ No If yes, when was your last:

Primary Care Physician exam, date _____

Endocrinologist exam, date _____

Podiatrist exam, date _____

Eye exam with dilation, date _____

Men and women (65 years old and older): Have you had a fall or difficulty with walking or balance within the past year?
❑ Yes ❑ No

Do you have an Advance Care Plan such as; Living will, DNR orders, Durable Power of Attorney, or health care proxy?
❑ Yes* ❑ No **If yes, please provide a copy for our records.*

Do you have a surrogate decision maker (someone you would like to have make decisions on your behalf if you do not have decision-making capacity) ❑ Yes ❑ No If yes, who: _____

If you drink alcohol: How many times in the past year have you had:

Men (64 years old or younger) 5 or more drinks per day? _____ times.

Men (65 years old or older) 4 or more drinks per day? _____ times.

Women (of all ages) 4 or more drinks per day? _____ times.

When was your last:

Men and women (50-75 years old) Colonoscopy, date _____ ❑ Never

Men and women (50-75 years old) Sigmoidoscopy, date _____ ❑ Never

Women (21-64 year old) Pap smear, date _____ ❑ Never

Women (50-74 years old) Mammogram, date _____ ❑ Never