HILL CENTER FOR DERMATOLOGY

PATIENT HEALTH SUMMARY

(Please Print) Today's Date: _____

Patient's Name: _____ Date of Birth: _____ Patient's Age: _____

Primary Care Physician: _____ Preferred Pronouns: _____

Pharmacy Name: _____ Location: _____

Do you give our office permission to discuss your medical information with family members, including but not limited to: biopsy results, blood/lab results, or other test results? **YES** **NO**

If **YES**, please provide their names and phone numbers below.

Name _____ Relationship _____ Phone _____

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Do you give permission for Hill Center for Dermatology staff to leave detailed messages at your preferred contact number regarding any tests that you may incur as a patient, including but not limited to: biopsy results, blood/lab results, or other test results? **YES** **NO**

Preferred Phone Number: _____ Type (circle): Cell Home Work

Reason for today's visit: _____

Medication Allergies: _____

List all medications you are currently taking, including prescriptions, over the counter, vitamins and herbals:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Have you been previously diagnosed with any of the following? (circle)

Anxiety
Arthritis
Type: _____
Asthma
Atrial Fibrillation/Irregular Heartbeat
Cancer (other than skin)
Type: _____
COPD
Coronary Heart Disease
Depression
Diabetes
End Stage Renal Disease
Hay Fever/Allergies
Hearing Loss
Heart Failure
Heart Valve Replacement
Hepatitis- Type: _____
Other (not listed above): _____
High Blood Pressure
High Cholesterol
HIV/AIDS
Immunosuppressed
Inflammatory Bowel Disease
Seizures
Stroke
Thyroid Disease: high or low

Have you had any of the following skin conditions? (circle)

Acne
Actinic Keratosis
Basal Cell Carcinoma
Blistering Sunburn
Dry Skin
Eczema
Melanoma
Psoriasis
Squamous Cell Carcinoma
Dysplastic or Atypical Moles
Other: _____

Please Turn Over and Complete the Back

Do you smoke? Never Former Current If yes, how much per day? _____
Do you use sunscreen? YES NO
Have you ever used a tanning bed? YES* NO ***Frequency of Use: _____**
Have you had a flu shot this season (October 1- March 31)? YES NO*****
***Are you allergic to the flu shot?** YES NO
Has anyone in your family had skin cancer? YES NO
If YES, relationship: _____ Type of skin cancer: _____

Patient's Height: _____ **Patient's Weight: _____**

REVIEW OF SYSTEMS/ALERTS INFO

Do you develop skin rashes or reactions to: Food Environment Bandages Antibiotic Ointment
Do you develop keloid scars (firm, thick scars)? YES NO
Do you have an Artificial Heart Valve? YES NO
Do you have a Defibrillator or Pacemaker? YES NO
Have you had an organ transplant? YES NO
Organ: _____ Year: _____
Do you have Pins or Rods? YES NO
Location: _____ Year placed: _____
Have you had an Artificial Joint Replacement? YES NO
Location:_____ Year placed: _____
Do you require antibiotics prior to procedures (including dental cleaning)? YES NO
Do you develop an adverse reaction to Epinephrine when used for local numbing? YES NO
If applicable: Are you pregnant? YES NO Breastfeeding? YES NO

If you are 65 or older, please answer the following questions:
Are you current with your pneumonia vaccine? YES NO

Do you have the following?
- ☐ Power of Attorney/Surrogate Decision Maker Name: _____ Phone: _____
- ☐ Living Will/Advanced Care Plan
- ☐ NONE

_____ _____ _____ _____
Patient/Guardian Signature **Date** **Reviewed by Medical Assistant** **Date**

Revised 04/19/2022