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PATIENT HEALTH SUMMARY

(Please Print)

Today's Date: _____

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

Primary Care Physician: _____

Pharmacy Name: _____ Location: _____ Phone: _____

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

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

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

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

Acne	Eczema	Squamous Cell Carcinoma
Actinic Keratosis	Hay Fever/Allergies	Dysplastic or Atypical Moles
Basal Cell Carcinoma	Melanoma	Other: _____
Blistering Sunburn	Poison Ivy	
Dry Skin	Psoriasis	

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

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: _____

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 a rapid heartbeat to Epinephrine? 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: _____
- Living Will/Advanced Care Plan
- NONE

Patient Signature

Date

Reviewed by Medical Assistant

Date