



**PATIENT HEALTH SUMMARY**

*(Please Print)*

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Patient's Age: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

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 \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

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

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

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

**\*\*\*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 Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Reviewed by Medical Assistant**

\_\_\_\_\_  
**Date**