Dina D. Strachan, MD, P.C. ***CONFIDENTIAL HEALTH HISTORY***

Name:_____ Today's Date:____/_____/_____

Age:_____ Date of Birth:_____/_____/_____ Gender: ☐ Male ☐ Female

What is the reason for your visit? _____

Dermatological history: Check ☑ all conditions you have previously been diagnosed with

☐ Acne
☐ Abnormal moles
☐ Allergic reactions
☐ Basal Cell carcinoma
☐ Eczema
☐ Hair Loss
☐ Hives
☐ Lupus
☐ Melanoma
☐ Psoriasis
☐ Sarcoidosis
☐ Squamous Cell carcinoma
☐ Scalp problems
☐ Warts
☐ Other: _____

Medical History **Please Check ☑ all that you have or have had in the past:**

☐ autoimmune disease
☐ Alcoholism
☐ Alleriges
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bipolar disorder
☐ Bleeding Disorder
☐ Bronchitis
☐ Cancer
☐ Cataracts
☐ Chicken Pox
☐ Depression
☐ Diabetes
☐ Eating disorder
☐ Epilepsy
☐ Glaucoma
☐ Goiter
☐ Gonorrhea
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Herpes
☐ High blood pressure
☐ HIV Positive
☐ Kidney Disease
☐ Liver Disease
☐ Measles
☐ Migraine Headaches
☐ Miscarriage
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Pacemaker
☐ Pneumonia
☐ Sarcoidosis
☐ Scarlet Fever
☐ Stroke
☐ Stomach ulcers
☐ Syphilis
☐ Thyroid Problem
☐ Tuberculosis
☐ Other: _____
_____

SYMPTOMS: Please Check ☑ All that you currently have or have had in the past year:

GENERAL
☐ Chills
☐ Joint ache
☐ Dizziness
☐ Fever
☐ Headache
☐ Loss of Weight
☐ Numbness
☐ Sweats
☐ shortness of breath

GASTROINTESTINAL
☐ Abdominal pain
☐ Constipation
☐ Diarrhea
☐ Nausea

EYE, EAR, NOSE, THROAT
☐ Bleeding Gums
☐ Double Vision
☐ Hay Fever
☐ Persistent Cough
☐ Sinus Problems
☐ Vision Problems

CARDIOVASCULAR
☐ Chest pain
☐ Irregular Heart Beat
☐ Swelling In Ankles
☐ Difficulty breathing

WOMEN Only
Last Menstrual Period (Date)**:**____**/**___**/**___
Are you pregnant? ☐ Yes ☐ No
☐ Abnormal Pap
☐ Irregular Periods
☐ Genital ulcers

MEN Only
☐ Penile discharge
☐ Penile Ulcer

MEDICATIONS: Please list ALL (include Birth Control, Over-The-Counter, Vitamins/Minerals, Prescriptions):

_____ _____ _____

_____ _____ _____

*****PLEASE TURN TO THE OTHER SIDE OF THIS PAGE AND CONTINUE*****

ALLERGIES TO MEDICATIONS:

☐ I have no known medication allergies.
☐ I am allergic to the following medications **(include Over-The-Counter, Vitamins/Minerals, herbs, etc)**

_____ _____ _____ _____

_____ _____ _____ _____

Other allergies (food, chemical, animals, environmental, etc):

☐ I have no other allergies.
☐ I am allergic to the following:

_____ _____ _____ _____

FAMILY HISTORY: Please Check ☑ ALL That Any Blood Relative has or has had:
☐ I am adopted and do not know my family history

☐ Acne	☐ Eczema	☐ Sarcoidosis
☐ Abnormal moles	☐ Hair loss	☐ Squamous Cell carcinoma
☐ Allergic reactions	☐ Lupus	☐ Thyroid disease
☐ Asthma	☐ Melanoma	☐ Diabetes
☐ Basal cell carcinoma	☐ Psoriasis	☐ Cancer

☐ Other: _____

HEALTH HABITS: Please Check ☑ ALL Substances/Activities You Use And Describe How Much:

☐ Alcohol: _____
☐ Caffeine: _____
☐ Street Drugs:_____
☐ Tobacco (smoke or chew): _____

SKIN CARE HABITS: Please check all that apply

☐ I apply sunscreen to my face every day
☐ I sunbathe
☐ I use tanning booths

How many times a day do you take a bath or shower? _____

Do you use hot water in your bath or shower? _____

How many times a day do you wash your face? _____

How many times a week to you shampoo your scalp? _____

What brands of cleanser to you use on your face? _____

body? _____

Do you apply a moisturizer to your body? Y/N? If yes, which brands _____

Face? Y/N If yes, which _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative ***Date***

_____ _____
Please Print Name of Patient, Parent, Guardian or Personal Representative ***Relationship To Patient***

_____ _____
Reviewed by ***Date***