Psoriasis & Eczema
TREATMENT CENTER
BY H2|DERMATOLOGY

HEALTH HISTORY

NAME: __ _____ **Date of Birth**_____

TELEPHONE NUMBER: (to reach you with information or results): _____

May we leave medical information or test results on your answering machine? Yes No

MEDICAL HISTORY:

1. Major illnesses/ Hospitalizations/ Chronic conditions: _____
   _____
2. Surgeries: _____
   _____
3. Do you have any of the following (check all that apply)

Hypertension (High Blood Pressure) Diabetes Hart Disease (Murmur)

Pacemaker Artificial Joints Artificial Heart Valves/ Stents

Explain checked Items: _____

_____

MEDICATIONS Name Dose How Often

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____
4. _____ _____ _____
5. _____ _____ _____

ALLERGIES TO MEDICATIONS: _____

Allergy to latex? Yes No Allergies to food or environment? _____

Do you need to take antibiotics prior to dental or surgical procedures? Yes No

Do you smoke? Yes No If yes, how much? _____ Do you drink alcohol? Yes No if yes, how much? _____

SKIN HISTORY: (list onset, duration, any treatments)

1. General Problems: _____
2. History of skin cancer: _____
3. Severe sun exposure: _____
4. Chronic X-ray treatment: _____
5. When exposed to sunlight, do you: Burn Burn-tan Tan Only

FAMILY MEDICAL HISTORY: (List any medical problems/ conditions of family members)

1. Mother: _____
2. Father: _____
3. Children: _____

Patient Signature: _____ Date: _____