Integrated Dermatology of Skin CALUMET CITY, LLC

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HEALTH HISTORY FORM

Patient Name _____ Account Number _____ Date _____

Age _____ Birthdate _____ Date of last physical examination _____

SYMPTOMS *Check symptoms you currently have or have had in the past year.*

GENERAL

☐ Weight change
☐ Chills
☐ Facial pain
☐ Felling tired or poorly (malaise)
☐ Forgetfulness
☐ Fever
☐ Headache
☐ Lump or swelling in the neck
☐ Numbness
☐ Neck stiffness
☐ Fainting
☐ Night sweats
☐ Excessive sweating

MUSCLE/JOINT/BONE

☐Joint Pain: ☐ Bone Pain:
☐ Arms ☐Hips
☐ Back ☐Legs
☐ Feet ☐Neck
☐ Hands ☐Shoulders

NEUROLOGICAL

☐ Anxiety ☐ Vertigo
☐ Dizziness
☐Sensory Disturbances
☐Motor Disturbances
☐ Sleep disturbances
☐Other: _____

GASTROINTESTINAL

☐ Appetite decreased
☐ Bloating
☐ Constipation
☐ Difficulty swallowing
☐ Excessive thirst (Polydypsia)
☐ Excessive hunger (Polyphagia)
☐ Bruise easily
☐ Gas (Flatus)
☐ Heartburn
☐ Abdominal pain
☐ Nausea
☐ Diarrhea
☐ Rectal bleeding
☐ Vomiting
☐ Vomiting blood

SKIN DISORDERS

☐ Acne ☐ Shingles
☐ Actinic Keratosis (precancers)
☐ Change in moles
☐ Eczema ☐ Warts
☐ Itching (Pruritus)
☐ Keloids ☐ Vitiligo
☐ Lupus
☐ MRSA Date:_____
☐ Psoriasis ☐ Rosacea
☐ Skin Cancer: Type_____
☐ Scabies ☐Other:_____

EYE, EAR, NOSE, THROAT

☐ Bleeding gums
☐ Blurred vision
☐ Crossed eyes (Strabismus)
☐ Double vision (Diplopia)
☐ Ear discharge
☐ Earache
☐ Eyes- sensitive to light
☐ Hearing loss
☐ Hoarseness
☐ Itching of the eyes
☐ Loss of hearing
☐ Nasal Discharge
☐ Nosebleeds (Epistaxis)
☐ Ringing in ears (Tinnitus)
☐ Sinus pain
☐ Vision – Flashes (Photopsia)

CARDIOVASCULAR/PULMONARY

☐ Chest pain or discomfort
☐ Cough
☐ Coughing up blood (hemoptysis)
☐ Fast heart rate
☐ Palpitations
☐ Shortness of breath
☐ Varicose veins
☐ Wheezing

GENITOURNIARY

☐Blood in urine (Hematuria)
☐Frequent urination (Polyuria)
☐Lack of bladder control
☐Painful urination (Dysuria)
☐ Other _____

MEN ONLY

☐Breast lump
☐Erection difficulties
☐Lump in testicles
☐Penis discharge
☐ Other _____

WOMEN ONLY

☐Hot flashes
☐Nipple discharge
☐Vaginal discharge
☐ Other _____

Date of last menstrual period _____

Have you had a Mammogram Within the last year? _____

Have you had a Pap Smear Within the last year? _____

Are you pregnant? _____

If yes, indicate due date _____

Are you planning pregnancy? _____

Are you using birth Control? _____ Type _____

Number of children _____

GENERAL HEALTH CONDITIONS *Check general health conditions you have or have had in the past.*

☐ AIDS
☐ Alcoholism
☐ Anemia
☐ Anorexia
☐ Autism
☐ Arthritis
☐ Asthma
☐ Bleeding disorders: Type_____
☐ Bronchitis
☐ Cancer: Type _____
☐ Cataracts
☐ Chemical Dependency
☐ Chicken Pox
☐ Diabetes: Type_____
☐ Depression
☐ Emphysema
☐ Epilepsy
☐ Glaucoma
☐ Organ Transplant Type_____
☐ Donor ☐ Recipient
☐ Gout
☐ Deep Vein Thrombosis
☐ Heart Disease: Type_____
☐ Hepatitis: Type_____
☐ Hernia
☐ Herpes: Type _____
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV
☐ Kidney Disease: Type_____
☐ Liver Disease: Type_____
☐ Heart Attack Date:_____
☐ Migraine Headaches
☐ Miscarriage
☐ Mononucleosis (Mono)
☐ Multiple Sclerosis
☐ Mumps
☐ Pacemaker: Date_____
☐ Pneumonia
☐ Polio
☐ Prostate Problem: Type_____
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Seizures
☐ Sexually Transmitted Disease: Type _____
☐ Stroke
☐ Suicide Attempt
☐ Thyroid Problems: ☐LOW / ☐HIGH
☐ Stents Type:_____
☐ Tuberculosis
☐ Typhoid Fever
☐ Stomach Ulcers
☐ Vaginal Infections: Type_____
☐ Artificial Joint Type:_____
☐ Other: _____