Foothills
Dermatology & Facial Plastic Surgery

PATIENT HEALTH HISTORY

Patient Name:_____ Date of Birth:_____

Height:_____ Weight: _____

Check all current or past medical conditions:

- ❑ Asthma
- ❑ COPD
- ❑ Emphysema
- ❑ Diabetes
- ❑ TIA
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Bleeding Disorder
- ❑ Problem Scarring
- ❑ Stroke
- ❑ Seizure Disorder
- ❑ High Blood Pressure
- ❑ Current Pregnancy
- ❑ HIV/AIDS
- ❑ Hepatitis B or C
- ❑ Depression Disorder
- ❑ Anxiety Disorder
- ❑ Thyroid Disease
- ❑ Blood Clots
- ❑ Angina/Chest Pain
- ❑ Skin Ulcers/Keloids
- ❑ Melanoma
- ❑ Unusual Moles
- ❑ Cancer Type:_____
- ❑ Heart Disease Type:_____
- ❑ Other:_____

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

List all current medications:_____

_____

List all drug allergies:_____

_____

List all past surgeries:_____

_____

Do you smoke or use tobacco: ❑ Yes ❑ No How much do you use daily?_____

Are you a past smoker or tobacco user? ❑ Yes ❑ No When did you quit?_____

Do you consume alcohol? ❑ Yes ❑ No How much do you consume daily?_____

Are you a past alcohol user? ❑ Yes ❑ No When did you quit?_____

Have any close relatives had any of the following?

❑ Melanoma ❑ Head or neck cancer ❑ Skin cancer other than melanoma ❑ Unusual mole

What is the nature of your visit?_____

I have read this questionnaire and answered the questions to the best of my knowledge. I am responsible to notify the office and the physician if any changes occur in my medical condition. If I fail to keep the doctor informed on my full medical history, I may be at an increased risk for complications or unexpected results from the planned treatments.

Patient Signature:_____ Date:_____

(Signature of a parent or legal guardian is required for patients under the age of 18 years.)