Patient Self-Health Assessment
Dermatology Associates of Southern New Hampshire

Name: _____ Date of Birth: _____

Who is your primary care physician? _____
Physician address: _____

CHIEF COMPLAINT:
What is the reason for your visit today? _____
How long has the problem been present? _____
Is it worsening? _____
Is there anything that improves the condition? _____
Have you treated the condition? _____

PAST MEDICAL HISTORY

DERMATOLOGIC

Have you had any of the following medical problems? (please check that which applies)	**YES**	**NO**	**DETAILS**
Skin cancer			
Basal cell carcinoma			
Squamous cell carcinoma			
Melanoma (mole cancer)			
Abnormal moles			
Psoriasis			
Eczema			
Severe acne			
Sunburns			
Poor wound healing			
Abnormal or red scars			
Other skin problems			

CARDIAC HISTORY

Have you had any of the following problems?	**YES**	**NO**	**DETAILS**
Heart attack			
Chest pain			
High blood pressure			
Stroke			
Heart arrhythmia			
Heart surgery			
Angioplasty			
Pacemaker			
Implanted defibrillator			
Take coumadin			
Take aspirin			
Take other blood thinners such as Plavix			
I see a cardiologist			

SURGICAL HISTORY **Have you had any of the following?**	YES	NO	DETAILS
Adverse reaction to local anesthesia			
Palpitations with local anesthesia			
Light headed with injection or blood draw			
Nausea with injection or blood draw			
Do you bleed excessively during surgery/procedures?			
Have you stopped coumadin prior to procedure?			
Have you stopped aspirin prior to procedure?			
Do you take antibiotics prior to procedures?			

FAMILY HISTORY **Have any close relatives had any of the following?**	YES	NO	DETAILS
Skin cancer			
Melanoma			
Unusual moles			
Eczema			
Psoriasis			
Severe acne			

SOCIAL HISTORY	YES	NO	DETAILS
Do you smoke?			
Have you ever smoked?			
If yes, how many years?			
Are you exposed to fumes, dust, solvents, or any airborne particles?			
How much alcohol do you drink?			
What is your occupation?			
What is your marital status? (M) (S) (D) (W)			

REVIEW OF SYSTEMS

GENERAL HEALTH **Have you had any of the following medical problems:**	YES	NO	DETAILS
Cancer (not including skin)			
Recent unexplained weight loss			
Organ transplant			
Food allergies			
Hepatitis			
Tuberculosis/HIV			
EYES			
Eye problems			
Eye surgery			

EARS/NOSE/MOUTH/THROAT			
Problems or surgery in these areas?			
RESPIRATORY			
Asthma			
Trouble breathing			
GENITOURINARY			
Kidney problems			
Urinary Problems			
Are you pregnant?			
Considering pregnancy			
GASTROINTESTINAL			
Stomach problems			
Bowel problems			
MUSCULOSKELETAL			
Joint replacement			
Arthritis			
PSYCHIATRIC			
Taking medication for condition			
Anxiety disorder			
Dementia			
ENDOCRINE			
Thyroid problem			
Diabetes			
Other endocrine problem			
HEMATOLOGIC/LYMPHATIC			
Family history of bleeding disorder			
Bruise easily			
Other blood disorder			

Please list any other medical conditions that we should be aware of:

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Patient Signature: _____

Date: _____

Physician Review

I have reviewed the above information with the patient.

Provider Signature: _____

E. William Frank, M.D./Rebecca Charters, P.A.-C.

Date: _____