Pacific Dermatology & Cosmetic Center

PATIENT HEALTH HISTORY (PAGE 1)

Patient Name_________________________________ Birth Date_____/_____/______ Today's Date____/_____/_______

Are you presently or frequently bothered by any of the following symptoms? Please check any that apply. Feel free to add chronic symptoms that aren't listed that you feel are important and/or a concern to you.

GENERAL ☐ None

☐ Unexplained Fever
☐ Unexplained weight loss or gain
☐ Night sweats
☐ Severe intolerance to hot or cold weather
☐ Excessive thirst

EYES, EARS, NOSE, THROAT ☐ None

☐ Double or blurred vision
☐ Ear or Hearing trouble
☐ Ringing in ears/head noise
☐ Frequent nose trouble
☐ Sore mouth or throat
☐ Difficulty swallowing

HEART - CIRCULATION ☐ None

☐ Chest pain
☐ Heart palpitations
☐ Leg vein trouble
☐ Ankle swelling

LUNGS - RESPIRATORY ☐ None

☐ Shortness of breath
☐ Chest pain with breathing
☐ Wheezing
☐ Daily cough
☐ Coughing blood

GENITOURINARY ☐ None

MALE

☐ Difficulty urinating
☐ Frequent urination
☐ Discharge from penis

FEMALE

☐ Frequent urinary tract infections
☐ Frequent yeast infections

☐ Unusual bleeding or discharge from vagina
☐ Pain with urinating

GASTROINTESTINAL ☐ None

☐ Diarrhea
☐ Blood in stool
☐ Frequent heartburn
☐ Bowel problems

BONES, JOINTS, MUSCLES ☐ None

☐ Joint pain or swelling
☐ Muscle pain or severe lack of strength

NEUROLOGIC ☐ None

☐ Dizziness
☐ Headache
☐ Numbness (body parts "go to sleep")
☐ Frequent loss of balance
☐ Tremor (shaking, trembling)
☐ Convulsions (seizures, fits, epilepsy)
☐ Memory problems

MOOD - PSYCHIATRIC ☐ None

☐ Depression (feeling blue)
☐ Stress or excessive worry
☐ Trouble getting along with people
☐ Sleep disturbance
☐ Hallucinations

ALLERGY/IMMUNOLOGY ☐ None

☐ Sneezing
☐ Red/itchy eyes

HEMATOLOGIC/LYMPHATIC ☐ None

☐ Bleeding easily
☐ Bruising easily
☐ Lymph node swelling

OTHER SYMPTOMS NOT LISTED ABOVE:

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