

# PSD Health History Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Please list all medications/dosages you are currently taking, **including all over-the-counter, alternative medications, vitamin or herbal supplements:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medications?  Yes  No / Please list: \_\_\_\_\_

Do you have any other allergies?  Yes  No / Please list: \_\_\_\_\_

Your Preferred Pharmacy \_\_\_\_\_ Location: \_\_\_\_\_

Check all conditions you currently have or have had in the past:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Actinic keratosis   | <input type="checkbox"/> Cancers                  | <input type="checkbox"/> Hepatitis C        | <input type="checkbox"/> Phlebitis              |
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> High cholesterol   | <input type="checkbox"/> Psoriasis              |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Hypertension       | <input type="checkbox"/> Renal (kidney) disease |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Depression               | <input type="checkbox"/> Liver disease      | <input type="checkbox"/> Rosacea                |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Eczema                   | <input type="checkbox"/> Lupus              | <input type="checkbox"/> Seizure disorder       |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Gastrointestinal disease | <input type="checkbox"/> Mental disorder    | <input type="checkbox"/> Thyroid disease        |
| <input type="checkbox"/> Blood clots         | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Tuberculosis           |

If you have had cancer – what type? \_\_\_\_\_

List any other diseases or conditions you may have: \_\_\_\_\_

List any surgical procedures (w/dates) you've had in the past year: \_\_\_\_\_

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**Family History** – Please indicate if any immediate family member has/had any of the following diseases:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Abnormal Moles          | <input type="checkbox"/> CVA (Stroke)               | <input type="checkbox"/> Keloids (bad scars)     |
| <input type="checkbox"/> Acne                    | <input type="checkbox"/> Depression                 | <input type="checkbox"/> Lupus                   |
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Dermatitis                 | <input type="checkbox"/> Malignant melanoma      |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Psoriasis               |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Eczema                     | <input type="checkbox"/> Renal (kidney) disease  |
| <input type="checkbox"/> Basal cell carcinoma    | <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Rosacea                 |
| <input type="checkbox"/> Blood disease           | <input type="checkbox"/> Hepatitis C                | <input type="checkbox"/> Seizure disorder        |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hyperlipidemia             | <input type="checkbox"/> Squamous cell carcinoma |
| <input type="checkbox"/> Cancer - Type? _____    | <input type="checkbox"/> Hypertension               | <input type="checkbox"/> Thyroid disorder        |
| <input type="checkbox"/> COPD                    | <input type="checkbox"/> Inflammatory bowel disease | <input type="checkbox"/> Other _____             |

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**Skin:**

Have you had skin cancer?  Yes  No Type/Area on body \_\_\_\_\_ Date \_\_\_\_\_

Do you have problems with healing?  Yes  No Do you or have you ever

Do you develop keloids (bad scars) after surgery?  Yes  No tanned indoors?  Yes  No

**Social History:**

What is your occupation? \_\_\_\_\_

Are you exposed to any occupational hazards?  Yes  No If yes, explain \_\_\_\_\_

Do you use tobacco?  Yes  No If yes, type? \_\_\_\_\_ / \_\_\_\_\_ packs/day

Do you drink alcohol?  Yes  No If yes, how many drinks per day/week \_\_\_\_\_

Do you use caffeine?  Yes  No If yes,  Coffee  Tea  Chocolate  Other \_\_\_\_\_

Are there animals in your home?  Yes  No If yes, what type? \_\_\_\_\_

Have you traveled out of state/country recently?  Yes  No If yes, where? \_\_\_\_\_

Do you have or ever been exposed to HIV/AIDS?  Yes  No

**Women:**

Are you pregnant?  Yes  No If yes, due date: \_\_\_\_\_

Are your menstrual cycles regular?  Yes  No Date of last cycle \_\_\_\_\_

Reviewing Provider Signature \_\_\_\_\_ Date reviewed: \_\_\_\_\_