MENLO MEDICAL CLINIC
Affiliated with Stanford Hospital & Clinics

Dermatology
Patient Health History

Reason For Visit:_____

Phone Numbers: Home (____)_____ Work (____)_____ Cell (____)_____

Primary Care Physician:_____ **Referring Physician**: _____

Medications: (Please include herbal supplements, vitamins, over –the-counter medications, and topical medications)

_____

_____

Allergies to medications: □ Yes □ No (Please Specify) _____

Review of Systems: Are you currently experiencing problems in any of the following areas? If yes, please explain.

	Yes	No		Yes	No
Fevers/Chills	□	□	Joint/Muscle _____	□	□
Eyes _____	□	□	Endocrine _____	□	□
Ears/Nose/Throat _____	□	□	Depression or Anxiety _____	□	□
Gastrointestinal _____	□	□	Allergy_____	□	□
Respiratory _____	□	□	Blood/Lymph _____	□	□
Cardiovascular _____	□	□	Neurologic _____	□	□
Genitourinary _____	□	□	Other_____		

Past Medical History / Family History

	Personal		Family			Personal		Family	
	Yes	No	Yes	No		Yes	No	Yes	No
Malignant Melanoma	□	□	□	□	Autoimmune Disorder	□	□	□	□
Basal Cell Carcinoma	□	□	□	□	HIV	□	□		
Squamous Cell Carcinoma	□	□	□	□	Cancer (type)__	□	□	□	□
Abnormal Moles	□	□	□	□	Liver / Hepatitis Problems	□	□	□	□
Psoriasis	□	□	□	□	High Blood Pressure	□	□	□	□
Eczema	□	□	□	□	Pacemaker	□	□		
Asthma	□	□	□	□	Mitral Valve Prolapse	□	□	□	□
Seasonal Allergies / Hayfever	□	□	□	□	Heart Valve Replacement	□	□		
Hypo / Hyper Thyroidism	□	□	□	□	Joint Replacement	□	□		
Diabetes	□	□	□	□	Blood Disorder	□	□	□	□
Arthritis	□	□	□	□	Other_____	□	□	□	□

Prior Surgeries: □ None _____

If you are Female: Are You Pregnant? □Yes □ No Trying to become pregnant? □Yes □ No

Breastfeeding? □Yes □ No

Do you drink Alcohol? □Yes □ No # of drinks/week_____ **Do you Smoke?** □Yes □ No How often?_____

Marital Status: □ Single □ Married □ Divorced □ Widowed **Occupation**:_____

Patient Signature _____ Date _____

Reviewed by (Physician): _____ Date _____