BEL-AMI® DERMATOLOGY
ADVANCED SKIN CARE, LASER, & SURGERY CENTER
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*BEAUTIFUL FRIEND

Kay A Johnston, M.D.
Board Certified Dermatologist

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Physician Assistant-Certified

Health History

Patient Name: _____

Age: _____Birth date: _____ Date of last full body exam: _____

Weight:_____Height:_____

Last Influenza Vaccine:_____Last Pneumonia Vaccine:_____

Check any of the following medical conditions that you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Benign Prostatic Hypertrophy (BPH)
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ Gastric Esophageal Reflux Disease (GERD)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other: _____

Check any surgeries you have had on the following organs:

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast Mastectomy (Right/Left/Both Breasts)-circle one
- ☐ Breast Lumpectomy (Right/Left/Both Breasts)-circle one
- ☐ Breast (Biopsy)
- ☐ Breast (Reduction)

- ☐ Breast (Implants)
- ☐ Colon (Colectomy): Colon Cancer
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart (Coronary Artery Bypass Graft)
- ☐ Heart (PTCA)
- ☐ Heart (Mechanical Valve Replacement)
- ☐ Heart (Biological Valve Replacement)
- ☐ Heart (Heart Transplant)
- ☐ Joint Replacement Knee (Left/Right/Both)-circle one
- ☐ Joint Replacement Hip (Left/Right/Both)-circle one
- ☐ Kidney (Biopsy)
- ☐ Kidney (Nephrectomy)
- ☐ Kidney (Stone Removal)
- ☐ Kidney (Kidney Transplant)
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy): TURP
- ☐ Skin (Basal Cell Carcinoma):
  Date: _____Location: _____
  Date: _____Location: _____
  Date: _____Location: _____

- ☐ Skin (Squamous Cell Carcinoma)—
  Date: _____Location: _____
  Date: _____Location: _____
  Date: _____Location: _____
  Date: _____Location: _____

- ☐ Skin (Melanoma)—
  Date: _____Location: _____
  Date: _____Location: _____
  Date: _____Location: _____
  Date: _____Location: _____

- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchidectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Other: _____

Have you had any of the following skin conditions? (Please check all that apply)

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sun burns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or itchy scalp
- ☐ Hay fever/allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Other: _____

Do you wear sunscreen?

- ☐ Yes
- ☐ No

If yes, what SPF? _____

Do you tan in a tanning salon?

- ☐ Yes
- ☐ No

Family History:

Do you have a family history of melanoma?

- ☐ Yes
- ☐ No

If yes, list which relative (s)? _____

Mother: Living_____Deceased_____Reason_____Health History_____
Father: Living_____Deceased_____Reason_____Health History_____

Medications/Vitamins you are currently taking:

_____
_____
_____
_____
_____
_____

Pneumonia Vaccine Date:_____Flu Vaccine Date_____

Medications you are allergic to:

_____
_____
_____
_____
_____
_____
_____

Social History Details: (check all that apply)

- ☐ Not sexually active
- ☐ Sexually active with one partner
- ☐ Sexually active with more than one partner
- ☐ Same sex partner
- ☐ Drug Use
- ☐ IV Drug Use
- ☐ Alcohol use: less than one drink per day
- ☐ Alcohol use: 1-2 drinks per day
- ☐ Alcohol use: 3 or more drinks per day
- ☐ Patient feels safe at home
- ☐ Patient feels unsafe at home
- ☐ None of the above
- ☐ Other: _____

Smoking Status:

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker

Review of Systems (check all that apply):

- ☐ Abdominal Pain
- ☐ Anxiety
- ☐ Artificial heart value
- ☐ Artificial joints within the past two years
- ☐ Bloody stool
- ☐ Bloody urine
- ☐ Blurry vision
- ☐ Changing mole
- ☐ Chest pain
- ☐ Cough
- ☐ Depression
- ☐ Fever or chills
- ☐ GI Upset with antibiotics
- ☐ Hay Fever
- ☐ Headaches
- ☐ Immunosuppresion
- ☐ Joint Aches
- ☐ Muscle Weakness
- ☐ Neck Stiffness
- ☐ Night sweats
- ☐ Pregnancy or planning a pregnancy
- ☐ Rash
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Skin color changes
- ☐ Sore Throat
- ☐ Thyroid problems
- ☐ Unintentional weight loss
- ☐ Wheezing
- ☐ Yeast infections with antibiotics

- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotic ointments
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ Pacemaker
- ☐ Need pre-medication of antibiotic prior to procedure
- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring
- ☐ Rapid heartbeat with epinephrine

Skin Type

- ☐ Always Burn, Never Tan
- ☐ Usually Burn, Difficult Tan
- ☐ Sometimes Burn, Average Tan
- ☐ Rare Burn, Tan With Ease
- ☐ Very Rarely Burn, Tan Very Easily
- ☐ No Burn, Tan Very Easily

Pharmacy Name: _____

Phone: _____