DERMATOLOGY
Associates of Central Florida
David Yrastorza, MD

Health History

Name:_____

Date of Birth: _____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial Joints
Asthma
Atrial Fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid Reflux)
Hearing Loss
Other _____
_____

Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Both)
Lumpectomy (Right, Left, Both)
Breast Biopsy (Right, Left, Both)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis

Joint Replacement, Knee (Right, Left, Both)
Joint Replacement, Hip (Right, Left, Both)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst

Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Basal Cell Carcinoma
Squamous Cell Carcinoma
Melanoma

Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Testicles Removed (Right, Left, Both)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Spleen Removed
None

Other: _____

Skin Disease History: (circle all that apply)

Acne
Actinic Keratoses
Melanoma
Precancerous Moles
Squamous Cell Carcinoma
Basal Cell Carcinoma
Blistering Sunburns
Eczema

Hay Fever/ Allergies
Asthma
Poison Ivy
Psoriasis
Dry Skin
Flaking or Itchy Scalp
None

Other: _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

Any other family history: _____

Current Medications: (please list all current medications) _____

_____

_____

Allergies: (please list all medication allergies) _____

_____

_____

Social History:

Tobacco Use: (please circle)

Smoke:	Never	Currently	Quit
Other tobacco:	Never	Currently	Quit
How long:		_____	_____
How much per day:		_____	_____
When did you stop?			_____

Alcohol Use: (please circle) Yes No

Race: White Black African American Asian

American Indian/Native Alaskan Native Hawaiian/Pacific Islander

Ethnicity: Non-Hispanic/Latino Hispanic / Latino

Language: English Spanish Other: _____

Pharmacy:

Name: _____

Street: _____

Zip code: _____ Phone: _____

How often do you exercise? Once a day A few times a week A few times a month Never

What is your caffeine use? Once a day A few times a week A few times a month Never

Occupation and Workplace:

_____

Place of residence:

_____