ADVANCED DERMATOLOGY CENTER, P.C.

710 ST. ANNE STREET, RAPID CITY, SD 57701 PHONE 605-343-8000

HISTORY FORM

DATE:_____ REFERRING PHYSICIAN:_____

NAME:_____

Please list backup contact and phone number if we are unable to reach you_____

AGE: _____ BIRTH DATE:_____ REASON FOR VISIT:_____

SOCIAL HISTORY:
Occupation: _____Alcohol use: _____Chew/smoke yes/no pk/day_____# yrs____
Marital status: _____ Children: _____
_____

PAST OR PRESENT ILLNESS: If YES, explain: _____

YES	NO		
____	____	Asthma	_____
____	____	TB	_____
____	____	Diabetes	_____
____	____	Drug use	_____
____	____	Heart/Lungs	_____
____	____	Hepatitis	_____
____	____	Cancer	_____
____	____	High Blood Pressure	_____
____	____	Urinary	_____
____	____	Stomach	_____
____	____	Muscle/Joints	_____
____	____	Blood Transfusions	_____
____	____	Unexplained weight loss	_____
____	____	Ear, nose, throat	_____
____	____	Memory, numbness	_____
____	____	Anemia, easy bruising	_____
____	____	Skin	_____

PAST OPERATIONS OR HOSPITALIZATIONS: _____
_____
_____

OTHER SIGNIFICANT ILLNESSES: _____
_____
_____

DO ANY DISEASES RUN IN THE FAMILY: _____
_____

use reverse side if more space is needed

PHARMACY: _____

DRUG ALLERGIES: if none, please state NONE)_____

CURRENT MEDICATIONS:

DATE:	DATE:	DATE:	DATE:

CURRENT MEDICATIONS:

DATE:	DATE:	DATE:	DATE: