Inland Dermatology Skin Care Center
Keith M. Gross, MD
Health History

Patient Name:_____ **Date of Birth:**___ /__ /__

A. **Have you ever had any of the following:**

1. Skin Cancer (Please list the cancer type, location and date of treatment

   _____

2. Hepatitis or blood transfusions (Please list dates)

   _____

3. Surgery (Please list all surgeries and dates)

   _____

4. Have you ever received a Pneumococcal Vaccine YES_____ NO_____

5. Asthma, Hay Fever, Sinus Problems	11. Psoriasis
6. Eczema or Skin Rashes	12. Migraine Headaches
7. Glaucoma	13. Diabetes
8. High Blood Pressure	14. Tuberculosis
9. Heart or Kidney Disease	15. Other Medical Problems:
10. Peptic Ulcer	_____

B. **Have you or your blood relatives every had any of the following?**
(please circle all that apply and list relative)

Psoriasis:_____	Eczema/Rashes:_____
Skin Cancer, Melanoma:_____	Asthma/Hay Fever:_____
Other Skin Problems:_____	Migraine Headaches:_____

C. **Are you allergic to any medication, foods, pollens, dust, animals, etc.**
(please list with symptoms)

_____

D. **Are you currently taking any medications? *(Please list)***

_____

E. **Females:**

Are you pregnant? YES____ NO____	Do you take birth control? YES____ NO____
Are you nursing an infant? YES____ NO____	Name of birth control_____
	Date of last menstrual period:_____

Referring Physician:_____ **Telephone:**_____

Address:_____

Patient/Guardian Signature:_____ **Date:**_____