



**BEACH CITIES
DERMATOLOGY
MEDICAL CENTER**



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520 NORTH PROSPECT AVENUE, SUITE 302 - REDONDO BEACH, CALIFORNIA 90277 (310) 325 - S K I N
 3831 HUGHES AVENUE, SUITE 504 - CULVER CITY, CALIFORNIA 90232 (310) 204 - D E R M
 927 DEEP VALLEY DRIVE, SUITE 165 - ROLLING HILLS ESTATES, CALIFORNIA 90274 (310) 798 - 1 5 1 5
 P.O. BOX 4384 - BIG BEAR LAKE, CALIFORNIA 92315 (909) 866 - 8 6 8 8

HEALTH QUESTIONNAIRE

Patient Name: _____

Reason for Visit: _____

MEDICATIONS

List all medications that you are using...**INCLUDE OVER-THE-COUNTER PILLS, CREAMS & VITAMINS ALSO!**

NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN

ALLERGIES

List all reactions to **MEDICINES & DRUGS** - Also include reactions to **FOODS & OTHER ALLERGENS.**

NAME	TYPE OF REACTION	NAME	TYPE OF REACTION	NAME	TYPE OF REACTION

HOSPITALIZATIONS

List all hospitalizations including surgeries, operations & medical illnesses.

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

MEDICAL HISTORY

Draw a **BIG CIRCLE** around YOUR current problems below.

UNDERLINE if there is a family history of any of these problems.

Check (☑) box to indicate if you have had of any other symptoms or diseases and write in age of onset.

- | | | |
|--|--|--|
| <input type="checkbox"/> CANCER
<input type="checkbox"/> ABNORMAL MOLES OR DYSPLASIA
<input type="checkbox"/> SQUAMOUS OR BASAL CELL CANCER
<input type="checkbox"/> ECZEMA
<input type="checkbox"/> PSORIASIS
<input type="checkbox"/> HERPES
<input type="checkbox"/> SYPHILIS
<input type="checkbox"/> GENITAL WARTS
<input type="checkbox"/> SCARS EASILY
<input type="checkbox"/> DIABETES
<input type="checkbox"/> DEPRESSION
<input type="checkbox"/> MENTAL ILLNESS | <input type="checkbox"/> MELANOMA
<input type="checkbox"/> FREQUENT BURNS
<input type="checkbox"/> HIVES
<input type="checkbox"/> GONORRHEA
<input type="checkbox"/> CHLAMYDIA
<input type="checkbox"/> MOLLUSCUM
<input type="checkbox"/> HAIR LOSS
<input type="checkbox"/> THYROID DISEASE | <input type="checkbox"/> HAY FEVER
<input type="checkbox"/> GLAUCOMA
<input type="checkbox"/> JAUNDICE
<input type="checkbox"/> COLITIS
<input type="checkbox"/> ARTHRITIS
<input type="checkbox"/> ANEMIA
<input type="checkbox"/> SEIZURES
<input type="checkbox"/> HEART PROBLEMS OR MURMUR
<input type="checkbox"/> MITRAL VALVE PROLAPSE
<input type="checkbox"/> HIGH BLOOD PRESSURE
<input type="checkbox"/> KIDNEY PROBLEMS OR STONES
<input type="checkbox"/> RECENT WEIGHT LOSS (HOW MUCH?) |
| <input type="checkbox"/> OTHER: _____
ALCOHOL - OZ. /WK. _____
SMOKING - CIG. / DAY _____ # YEARS _____
COFFEE / TEA - CUPS / DAY _____
<h3 style="text-align: center; margin: 0;">F E M A L E S</h3> <input type="checkbox"/> REGULAR MENSTRUAL PERIODS
NUMBER OF: PREGNANCIES _____
LIVE BIRTHS _____
MISCARRIAGES _____
BIRTH CONTROL METHOD _____ | | |

Check (☑) box if you used the back of this sheet for additional space. ☐