Beth Israel Deaconess Medical Center
Boston, MA 02215

PATIENT SELF-HEALTH ASSESSMENT
Department of Dermatology

PATIENT'S NAME ____________________

MED. REC. # ____________________

DOB ____________________

Patient Identification

MR1310

Who is your primary care doctor: ____________________

Primary care doctor's address: ____________________

Who referred you to BIDMC Dermatology: ____________________

Reason(s) for today's visit: ____________________

If you answer Yes to any of the questions below, please explain in the DETAILS space provided on the right-hand side of this form. Thank you.

CURRENT HEALTH	No	Yes	DETAILS
Are you currently feeling in good health?	☐	☐	
Have you lost weight recently?	☐	☐	
Do you have red, swollen, or itchy eyes?	☐	☐	
Do you have a hard time swallowing?	☐	☐	
Do you have trouble with wheezing?	☐	☐	
Are you or could you be pregnant? Date of last period: ____/____/____	☐	☐	
Are you thinking about getting pregnant?	☐	☐	
Are you breastfeeding?	☐	☐	
Are you having abdominal (stomach) pain?	☐	☐	
Have you had a change in bowel habits?	☐	☐	
Do you have pain or swelling in your joints?	☐	☐	
Is it hard to move your joints?	☐	☐	
Are you currently depressed or anxious, and/or taking medicine for these problems?	☐	☐	
Have you been more thirsty or sweating more?	☐	☐	
Do you have a hard time in hot or cold weather?	☐	☐	
Do you have painful or enlarged glands?	☐	☐	
Do you bruise easily?	☐	☐	
FAMILY HISTORY			
Have any close relatives had any of the following?	**No**	**Yes**	**DETAILS**
Melanoma	☐	☐	
Skin Cancer	☐	☐	
Unusual mole (dysplastic or atypical)	☐	☐	
Severe acne	☐	☐	

ALLERGIES (List all Allergy / Sensitivity / Medication Reactions): ☐ **No Known Allergies**

Medication:

Food / Other:

MEDICATIONS (List all medications you are currently taking: Include prescription drugs, estrogen therapy, birth control pills, over the counter medications and/or herbals): ☐ **See List**

Medication / Drug Name	*Dose / How Taken*	*Time / How Often*	*Reason for Medication*

PLEASE COMPLETE OTHER SIDE

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YOUR PAST MEDICAL HISTORY			DETAILS
Have you ever had any of the following medical problems? (Please circle the problem and check Yes)	No	Yes	
Melanoma / Skin cancer / Unusual (dysplastic) moles	☐	☐	
Heart disease / Angina / Chest pain	☐	☐	
Cancer (type: ____________________)	☐	☐	
High blood pressure / High cholesterol	☐	☐	
Mitral valve prolapse / Heart murmur	☐	☐	
Asthma / Hay fever / Hives / Eczema / Psoriasis	☐	☐	
Diabetes / Kidney disease / Organ transplant	☐	☐	
Pneumonia / Tuberculosis / Chicken pox	☐	☐	
HIV or AIDS / Hepatitis / Liver disease	☐	☐	
Thyroid disease	☐	☐	
Anemia / Blood or plasma transfusions	☐	☐	
Stomach ulcers / Acid reflux	☐	☐	
Longer time bleeding during surgery / Blood clots	☐	☐	
Poor wound healing / Skin ulcers / Keloid scarring	☐	☐	
Seizures / Epilepsy / Stroke	☐	☐	
Depression / Anxiety / Psychiatric condition	☐	☐	
Do you need to take antibiotics prior to surgery / dental procedures?	☐	☐	
Other: ____________________			
SOCIAL HISTORY	**No**	**Yes**	**DETAILS**
Blistering sunburns / A lot of sun exposure?	☐	☐	
Use of tanning booth?	☐	☐	
Do you smoke?	☐	☐	
Have you ever smoked?	☐	☐	If Yes, how many years? ________
Are you exposed to fumes, dust, solvents, or any airborne particles?	☐	☐	
Do you drink alcohol?	☐	☐	If Yes, how much? ________
What is your occupation? ____________________			
What is your marital status? ☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Widowed			
What are your hobbies? ____________________			

I have answered these questions the best I could. I understand that giving incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

X____________________ Patient's Signature ____________________ Print Name **OR**

X____________________ Signature of Person authorized to sign for patient ____________________ Print Name and ____________________ Relationship to patient

Date: ___/___/___ **Time:** __ __ : __ __ ○ a.m. ○ p.m.

I have reviewed the above information with the patient.

☐ Interpreter present Language: ____________________

Comments: ____________________

____

X____________________ **Circle:** N.P. / M.D. - Signature ____________________ Print Name ___/___/___ Date __ __ __ __ Time (24 hour)

MR1310