MEDICAL INFORMATION FORM

DATE: _____

I was referred by: _____

Name: (Last) _____ (First) _____

In the past, I have been treated by provider:

Date of Birth: ___/___/___

Neish Paul Stratthaus (circle if applicable)

1. DRUG ALLERGIES: NO□ YES□ LIST: _____

2. Review of Systems: Do you currently have any of the following? If so, please check/explain:

Arthritis/Joint Disease	□	_____	HIV Positive	□	_____
Blood Disorder	□	_____	Immunological Disease	□	_____
Cancer	□	_____	Lupus	□	_____
Diabetes	□	_____	Liver Disease	□	_____
Dry Eyes/Dry Mouth	□	_____	Kidney/Bladder Disease	□	_____
Eye Disease	□	_____	Neurologic Disorder	□	_____
Stomach/Bowel Disorder	□	_____	Prostate Disease	□	_____
Hayfever/Asthma	□	_____	Psychiatric Disorder	□	_____
Hearing Loss	□	_____	Respiratory Disease	□	_____
Heart Disease	□	_____	Skin Diseases	□	_____
Heart Valve	□	_____	Stress/Anxiety/Depression	□	_____
Herpes Virus Cold Sore	□	_____	Thyroid Disease	□	_____
High Blood Pressure	□	_____	Vascular Disease	□	_____

3. PAST MEDICAL HISTORY: List relevant history

_____

_____

4.PAST SURGICAL HISTORY: List procedures and operations

_____

_____

5. FAMILY MEDICAL HISTORY:

	Mother	Father	Other Blood Relative
Arthritis/Lupus	□	□	□
Asthma	□	□	□
Cancer	□	□	□
Diabetes	□	□	□
Eczema	□	□	□
Hair Loss	□	□	□
Hayfever/Allergies	□	□	□
Heart Disease	□	□	□
High Blood Pressure	□	□	□
Lung Disease	□	□	□
Melanoma	□	□	□
Other Skin Cancer	□	□	□
Psoriasis	□	□	□
Thyroid Disease	□	□	□

6. SOCIAL HISTORY:

Do you drink alcohol? YES □ NO□

Do you smoke? YES □ NO□

If previous smoker, date quit: _____

Do you use recreational drugs? YES □ NO□

Occupation: _____

Marital Status: (Circle one) S M D W

Other family members treated here:

_____ _____ _____

Females Only:

Are you pregnant? YES □ NO□

Planning to become pregnant soon? YES □ NO□

Breastfeeding? YES □ NO□

Are your periods regular? YES □ NO□

If no, explain: _____

7. Your Skin: When you are exposed to the sun do you:

Tan only □ Burn first then tan □ Burn only □

Get a sun rash: (Circle one) YES NO

Facial skin is: Normal □ Oily □ Dry □ Mixed □

Completed by: □ Patient
□ Parent/Guardian
□ Medical Assistant

□ All of the above systems were noted. Patient findings are checked or documented.

_____ MD initials

8. Complete Skin Exam: (For ages 14 and older) (Circle one)

I would like to have a complete skin examination. YES NO

X *Patient Signature*: _____

(Parent/Guardian please sign if child is under 18 years of age)