BENJAMIN RAAB, M.D. • Dermatology & Cosmetic Skin Surgery

PATIENT HISTORY FORM (Please Print or type)

NAME:		AGE:		DATE:	

1. Have you previously been, or are you being treated for any of the following?

	Diabetes		Wasting of the Bones (i.e., Osteoporosis)
	Heart Failure		Chronic Kidney Disease
	History of Rheumatic Fever		Stomach or Duodenal Ulcer
	Angina		Tuberculosis
	Heart Murmur		Cold Sores in Eyes
	Clotting Tendencies		Diverticulitis
	Bleeding Tendencies		Mental Disturbance

2. Do you have any other medical problems?		If yes, please list:

3. Previous surgeries or operations. Please list:

4. Past Hospitalizations:

5. Please list all pills, medications or tablets you are taking:

6. Has a doctor given you anything for the skin?		If yes, please list:
7. Have you put anything else on your skin?		If yes, please list:
8. Are you allergic to any medicines? (Penicillin, aspirin, Sulfa, etc.)		If yes, please list:

9. Have you had skin cancer?		Any other skin problems?		If yes, please list:

10. Does anything touching your skin cause a rash or allergy? (Jewelry, Poison Oak, perfumes, etc.)		If yes, please list:			
11. Does anyone in your family have skin problems or rashes?		If yes, please list problem and relationship:			
12. Do you now have, or have you ever had Eczema?		Asthma?		Hay Fever?	
FOR WOMEN: Are you pregnant?		Are you taking hormones or birth control?			
If yes, please name:					