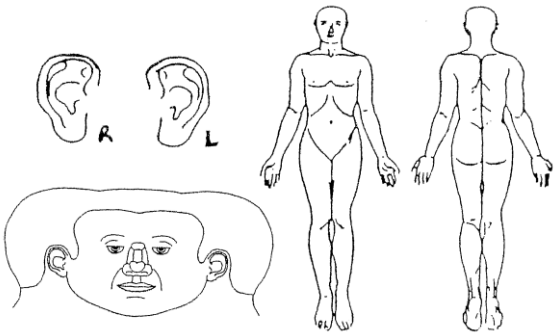
ACCOUNT #_____

PLEASE PRINT

BRIEF MEDICAL HISTORY FOR DR. ECKER



Name: _____Age: _____

Have we seen you in our office before this visit? ☐YES ☐ NO

How long ago? ___ Week(s) ___ Month(s) ___ Year(s)

PLEASE MARK THE SITE ON THE DIAGRAM

What is your skin problem? (rash, growth, acne, warts, cosmetic consult, etc.)_____

How long have you had this problem? _____ Week(s) _____ Month(s) _____ Year(s)

Please list any treatments or medications prescribed by other Doctors for this condition:_____

_____

How long/often did you use it? _____ Doctor's Name: _____

Please list any over-the-counter medications you have used for this condition: _____

_____How long/often did you use it? _____

PLEASE CIRCLE "YES" OR "NO" AND ANSWER THE FOLLOWING:

Are you allergic to any medicines? (penicillin, aspirin, etc.) ☐YES ☐ NO

If yes, please list medication and describe your reaction: _____

Have you had other skin problems? (Including childhood) ☐YES ☐ NO

If yes, please list: _____

Does anyone in your family have similar skin problems? ☐YES ☐ NO

If yes, please list and explain: _____

Is there anything else we should know about your health? (recent surgery, diabetes, stomach ulcers, easy bleeding, etc.) ☐YES ☐ NO

_____

Would you like any information about skin care products or cosmetic procedures? ☐YES ☐ NO

If yes, please specifiy: _____

FOR WOMEN: Are you nursing? ☐YES ☐ NO

Are you pregnant? ☐YES ☐ NO

FOR OFFICE USE:

Is this a referral from a medical provider?

☐**YES** ☐ **NO** If yes, whom? _____

Referral for: Office Visit Consult Surgery Other _____

LN2: Dx _____ **#**_____**Time** _____ **By** _____

Dx _____ **#**_____ **Time** _____ **By** _____

BX: TB PB SR EXC C&E F/U Lab: CALL APPT

Location(s) _____ **ICD9** _____

ICD9 _____

ICD9 _____

ICD9 _____

ICD9 _____

INJ: Amt _____**Med** _____**#**_____**Dx**_____**By**_____

Location_____ **KOH Prep FCX PCX**

Charge: LV1 LV2 LV3 _____**Wks** _____**Mos** _____**PRN**

Treatment Notes:

Initial:

Accompanied by: