STOCKTON DERMATOLOGY

Hair History

Patient: _____ **Date:** _____ **DOB:** _____ **Allergies:** _____
History Form Dated: Yes No Reviewed: Yes No Changes: Yes No Significant Findings: _____
Any new skin/hair problems? No Yes _____ Prior Records Reviewed _____ Pt otherwise feeling: well not well
Constitutional: WD/WN Yes No Neuro/Psy: Alert and Oriented Yes No Mood good: Yes No Affect: wnl Yes No

Present Hair Problem

When did the hair condition **begin**? _____ Puberty? Pregnancy? Menopause? Other _____
Any **previous history** of similar problem? Yes No **How Long Ago**? _____
Was it **treated** in the past? Yes No **What treatment** was used? _____ **Did it help**? Yes No
Was the **cause** identified? Yes No Was **lab work** done? Yes No Was the lab work **normal**? Yes No
Did the current hair condition begin **Slow** **Gradual** **Months to Years** **Fast, a few weeks to months** **Not Sure** ?
Have you recently **started** or **stopped** any **medication(s)**, including **birth control** or **hormones** when this started? Yes No
Please list any recently started or stopped medication(s) _____
Please list **current over-the-counter medicines, supplements** and **prescription** medications. (i.e., vitamins, aspirin, laxatives)

_____ _____ _____

Medical History

Please circle **all** conditions you may have **now** and/or in the **past.**

Anemia (low iron)	Brittle Nails	Changes in Menstruation	Changes in Tone of Voice
Diabetes	Fertility Problems	High Blood Pressure	History of Fibroids
Hormone Disorders	Increased Fatigue	Increased Stress	Kidney Problems
Liver Problems	Lupus	Polycystic Ovarian Disease	Recent Infection
Recent Pregnancy	Recent Surgery	Severe Acne	Thyroid Problems
Vitiligo	Weight Loss	Other _____	Other _____

Is there a **family history** of similar **hair problems**? Yes No Which family member? _____
Please circle family history of the following? Diabetes Lupus Thyroid Condition Uterine Fibroids Vitiligo

Hair Loss Problems

When did any hair loss **begin**? _____ **Where** on your **scalp** are you losing hair? _____
Are you losing hair from **anywhere else**? Yes No **From Where**? Eyebrows Eyelashes Other _____
Is the hair loss **Constant** **Worsening** **Improving** **Stable** ? Do you lose more than 100 hairs per day? Yes No
Is the hair **Coming Out at the Roots** or **Breaking Off** ? Are there any **scabs** or **pus** on the scalp? Yes No
Is your scalp **Itchy** **Tender** **Painful** **Sore** **Sensitive** ? Do you **pull** or **twist** your hair? Yes No

Hair Growth Problems

Where is the new hair? **Face** **Around Mouth** **Chin** **Cheeks** **Neck** **Arms** **Body** Other _____
Are the hairs **thick**? Yes No Is it **getting worse** recently? Yes No
Current Hair Removal: Bleaching Depilatories Electrolysis Laser Plucking Shaving Threading Waxing Vaniqa

Hair Care

Chemical Treatment(s)? Yes No How **Often**? _____ Last Treatment **When**? _____ **Type**? _____
Did/Does the treatment affect the hair loss? Yes No How? _____
How **often** do you shampoo? _____ Which **shampoo**? _____ **Conditioner**? _____
Does anything make the hair problem **Worse**? Yes No What? _____ **Better**? Yes No What? _____
Please circle all hair care products or items used.

Air-dry Hair	Blow-dry Hair	Curling Iron	Elastic Hair Items	Hair Pieces	Wet-Set Hair
Hair Weaves	Headbands	Hot Combs	Hot Rollers	'Tight' Style (pony tail, braids)	

Provider Signature _____ Date _____ TCS 3/07

STOCKTON DERMATOLOGY

Dermatitis History EM

Patient: _____ **Date:** _____ **DOB:** _____ **Allergies:** _____

History Form Dated: Yes No Reviewed: Yes No Changes: Yes No Significant Findings: _____

Any new skin problems? No Yes _____ Prior Records Reviewed _____ Pt otherwise feeling: well not well

Constitutional: WD/WN Yes No Neuro/Psy: Alert and Oriented Yes No Mood good: Yes No Affect: wnl Yes No

History

When did the rash **begin**? _____ **How long** has it been occurring? _____

Where did the rash **begin**? _____ **Where** is the rash **now**? _____

Is the rash? (Please Circle) **Slightly Itchy** **Moderately Itchy** **Severe Itchy** **Not Itchy at All**
Painful **Sensitive** **Burning** **No Symptoms**

Any recent changes in lifestyle? No Yes What? _____

History of **Allergies**? (Please Circle Below)

Hay Fever **Sinus Problems** **Asthma** **Eczema** **Cosmetics** **Foods** **Sunscreens**
Jewelry Other _____ Other _____

Family History of Allergies? No Yes What type? _____

Have you had any **previous** rashes? No Yes If yes, was it similar to this rash? No Yes

Has the current rash been **treated already**? No Yes By whom? _____ How? _____

Have you tried any **over-the-counter** products? (Please Circle Below) No Yes Did it help? No Yes A Little

Hydrocortisone Cream **Antifungal Creams** (Lotrimin, Clotrimazole, Lamisil, Nystatin, Other _____)

Antibiotic Cream or **Ointment** (Neosporin, Polysporin, Bacitracin, triple antibiotic, Other _____)

Mercurochrome **Powders** (Gold Bond) **Soaks** (Epsom Salts, Baking Soda Salt Water)

Have you tried any **prescription** medications? No Yes Did it/they help? No Yes A Little

Steroids by mouth (Medrol Dosepak, Prednisone) or on the skin? No Yes What type? _____

Antibiotics by mouth, by injection or on the skin? No Yes What type? _____

Antifungals by mouth (Diflucan, Lamisil, Sporonox) or on the skin? No Yes What type? _____

Any **systemic medications**? Please Circle Below)

Protopic **Elidel** **Tegison** **Soriatane** **Methotrexate** **Enbrel**

Any **light therapy**? No Yes What type? UVB PUVA BLU-U Other _____

Please List the Brand Name of the Following Products in the Spaces Provided

What soap are you using? _____ What lotion are you using? _____

Shampoo? _____ Deodorant? _____

Make-up? Eye Shadow _____ Foundation _____ Mascara _____

Eye Liner _____ Blush _____ Lipstick _____ Lip Liner _____

Hair Dye? _____ Other Hair Products? _____ Cologne or Perfume? _____

Shaving Products? _____ Laundry Detergent? _____ Nail Cosmetics? _____

Toothpaste? _____ Contact Lens Solution? _____ Pets? _____

Materials at Work? (i.e. machine oils) _____ At Home? (i.e. cleaning products) _____

Hobbies or Sports? _____ Jewelry? _____ Recent Vacations? _____

Other Current Medications _____

Other Medical Problems _____

Provider Signature _____ Date _____

STOCKTON DERMATOLOGY

Blemish/Complexion Problems/Acne/Rosacea EM

Patient Name: _____ **Date:** _____ **DOB:** _____

How long have you had your skin problem? _____ Location: **Face** **Neck** **Back** **Chest** □ Other _____
Would you say that it is **Mild** **Average** **Moderate** or **Severe**?
Any family history of these same symptoms/conditions? □ Yes □ No Who? _____
Past treatment? □ Yes □ No By a Dermatologist? □ Yes □ No By a Primary Care Doctor? □ Yes □ No
Are you using acne medications? □ No □ Yes What? _____ Is it helping? □ Yes □ No
Current Facial Products: AM Cleanser Name_____ PM Cleanser Name _____
Toner _____ Moisturizer _____ Mask _____
Sunscreen/Moisturizer_____ Make-up Type _____ Oil Free? □ Yes □ No

Have you used any previous over-the-counter or prescription products? Please Circle All That Apply.

Over-The-Counter Topical Products:

Benzoyl Peroxide (oxy-5) Clearasil Salicylic Acid Alpha Hydroxy Acids (glycolic acid)
Pro-Active Other _____ Other _____

Prescription Topical Products:

Erythromycin □ Solution □ Gel □ Ointment □ Pledgettes (i.e. A/T/S, Erygel, Emgel, Aknemycin)
Clindamycin (Cleocin, Clindagel) □ Solution □ Gel □ Lotion □ Pledgettes
Benzoyl Peroxide □ Gel □ Wash **Metrogel** □ Lotion □ Cream **Lustra** □ AF □ Ultra
Rozula □ Gel □ Wash **Plexion** □ Cleanser □ TS □ SCT **Differin** □ Cream □ Gel □ Solution

Azelex	**Finivin**	**Novacet**	**Sulfacet R**	**Klaron**	**Rosanil**	**Finacea**
Triaz	**Benzamycin**	**Benzaclin**	**Brevoxyl**	**Retin-A**	**Renova**	**Duac Gel**
Tazorac	**Avage**	**Tretinoin**	**Avita**	**Ziana**	Other _____	

Oral Medications:

Tetracycline **Doxycycline** (Adoxa, Monodox, Doryx) **Oracea** **Ampicillin**
Bactrim **Spironolactone** **Accutane** **Erythromycin**
Minocycline (Dynacin, Minocin, Solodyn) Other _____

Skin Treatments: Were treatments done in a doctor's office? □ **Yes** □ **No**

Facials **Masks** **Chemical Peels** □ Glycolic □ Salicylic Acid □ Jessner's □ TAC □ Obaji
Microdermabrasion **Photofacials** **Laser** **Acne Surgery** **Cryotherapy**
Light Therapy Effect of Treatment _____

Does your skin get worse with **Stress** **Certain Foods** **Menses** **Cosmetics** **Medications/Vitamins**
Work (chemical exposure) **Sports** (sweating/friction) **Worse after Pregnancy** Other _____
Does your skin get better with **Sun** **Relaxation** **Seasons** Other _____? **Nothing Makes it Better**

For Women:

Menstrual Cycle **Regular** **Irregular** **Pregnant?** **Breast Feeding?** **Excessive Hair Growth**
Birth Control? □ Yes □ No Type? _____ Name? _____ How Long? _____
Recently stopped birth control? □ Yes □ No Are you currently trying to become pregnant? □ Yes □ No

Provider Signature _____ Date _____