Solano Dermatology Associates **2290 Sacramento Street** **Vallejo, CA 94590**	**Patient Name:** **DOB:** **Referring MD:**

PEDIATRIC DERMATOLOGY – HEALTH HISTORY

Did someone refer you to us? (NAME) ______________________________

What is your child's main skin concern today: ______________________________

How long has it been present: ______________________________

Treatment to date: ______________________________

______________________________Did it help? ______________

Any other skin problems that need to be addressed today? ______________________________

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Dry/sensitive skin? Yes No   Eczema? Yes No

Asthma? Yes No   Hay fever? Yes No

PHYSICIAN

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PAST MEDICAL HISTORY   Birth History: _____Normal _____C-section   Wt. ______lbs ____oz.

Any health problems? ______________________________

Prior surgeries or hospitalizations? ______________________________

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Please list current/other medications: ______________________________

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Adverse reactions: (Drug, herbal)? ______________________________

Allergies (foods/other)? ______________________________

Are your child's immunizations up-to-date? Yes No

Your child's school and grade: ______________________________

PHYSICIAN

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MEDICAL PROBLEMS **Please describe yes responses**	**CHILD**	**FAMILY HISTORY** **Please state relationship to child for yes responses**
Skin cancer/melanoma	YES / NO	Skin cancer:
Headaches	YES / NO	Melanoma:
Epilepsy/Seizure Disorder	YES / NO	Eczema:
Ear / Nose / Throat	YES / NO	Asthma:
Heart Problems	YES / NO	Hay fever:
Breathing difficulties	YES / NO	Other:
Stomach pain, vomiting, diarrhea	YES / NO	
Muscle aches/weakness	YES / NO	Siblings/Age:
Bladder problems	YES / NO	
Learning/development problems	YES / NO	

PHYSICIAN

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