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? ____________________

____

Dry/sensitive skin? Yes No   Eczema? Yes No

Asthma? Yes No   Hay fever? Yes No

PHYSICIAN

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

Any health problems? ____________________

Prior surgeries or hospitalizations? ____________________

____

Please list current/other medications: ____________________

____

Adverse reactions: (Drug, herbal)? ____________________

Allergies (foods/other)? ____________________

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

Your child's school and grade: ____________________

PHYSICIAN

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