ADVANCED DERMATOLOGY OF THE BLACK HILLS, P.C.
710 ST. ANNE STREET, RAPID CITY, SD 57701 PHONE 605-343-8000

HISTORY FORM

DATE:______________________ REFERRING PHYSICIAN:________________________________

NAME:____

Please list backup contact and phone number if we are unable to reach you________________________

AGE: _________ BIRTH DATE:______________ REASON FOR VISIT:________________________

SOCIAL HISTORY:
Occupation: _________________Alcohol use: ________Chew/smoke yes/no pk/day_______# yrs____
Marital status: ________________________ Children: ________________
____

PAST OR PRESENT ILLNESS:			If YES, explain: ___________________________
YES	NO		
____	____	Asthma	____
____	____	TB	____
____	____	Diabetes	____
____	____	Drug use	____
____	____	Heart/Lungs	____
____	____	Hepatitis	____
____	____	Cancer	____
____	____	High Blood Pressure	____
____	____	Urinary	____
____	____	Stomach	____
____	____	Muscle/Joints	____
____	____	Blood Transfusions	____
____	____	Unexplained weight loss	____
____	____	Ear, nose, throat	____
____	____	Memory, numbness	____
____	____	Anemia, easy bruising	____
____	____	Skin	____

PAST OPERATIONS OR HOSPITALIZATIONS: ____
____
____

OTHER SIGNIFICANT ILLNESSES: ____
____
____

DO ANY DISEASES RUN IN THE FAMILY: ____
____

use reverse side if more space is needed

PHARMACY: ____

DRUG ALLERGIES: if none, please state NONE)______________________________

CURRENT MEDICATIONS:

DATE:	DATE:	DATE:	DATE:

CURRENT MEDICATIONS:

DATE:	DATE:	DATE:	DATE: