The Vitiligo and Pigmentation Institute of Southern California

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MEDICAL HISTORY

PLEASE PRINT

Name : ____
Last First Middle Initial

Date of Birth : ____/____/____ **Age:** _____ **Sex:** M F **Height** ______ **Weight** _____

Chief Complaint/Reason for Today's Visit : ____

Please check all items that apply to you and/or Family Members (write family member name in space provided) Y= YOU F= FAMILY

Y	F		Y	F		Y	F	
☐	☐	Eczema ________	☐	☐	Hearing Problems ________	☐	☐	Heart Murmur ________
☐	☐	Psoriasis ________	☐	☐	Glaucoma ________	☐	☐	Palpitations ________
☐	☐	Rash ________	☐	☐	Cataracts ________	☐	☐	Irregular Pulse ________
☐	☐	Acne ________	☐	☐	Coronary Heart Disease ________	☐	☐	Varicose Veins ________
☐	☐	Abnormal Moles ________	☐	☐	Venereal Disease ________	☐	☐	Phlebitis ________
☐	☐	Hives ________	☐	☐	Herpes ________	☐	☐	Thyroid Disease ________
☐	☐	Freq. Sun Exposure ________	☐	☐	High Cholesterol ________	☐	☐	Seizures ________
☐	☐	Excessive Scarring ________	☐	☐	Colitis ________	☐	☐	Stroke ________
☐	☐	Skin Cancer ________	☐	☐	Jaundice ________	☐	☐	Tuberculosis ________
☐	☐	Alopecia Areata ________	☐	☐	Hepatitis ________	☐	☐	Chronic Fatigue Syndrome ________
☐	☐	Recent or Progressive Hair Loss ________	☐	☐	Kidney Stones ________	☐	☐	Scleroderma ________
☐	☐	Cosmetic Issues ________	☐	☐	Prostate Problems ________	☐	☐	Depression ________
☐	☐	Dark Spots ________	☐	☐	Epstein Barr Syndrome ________	☐	☐	High Blood Pressure ________
☐	☐	Pigmentation Loss ________	☐	☐	Recent Weight Loss ________	☐	☐	Urinary Problem ________
☐	☐	Mental Illness ________	☐	☐	Cancer ________	☐	☐	Difficulty Swallowing ________
☐	☐	Cardiovascular Heart Disease ________	☐	☐	Diabetes ________	☐	☐	Mental Illness ________
☐	☐	Cancer (Colon, Breast or Prostate) ________	☐	☐	Heartburn ________	☐	☐	Bleeding Disease ________
☐	☐	Neurological Disease (Stroke, Seizures, etc..) ________	☐	☐	Peptic Ulcer Disease ________	☐	☐	Bruise Easily ________

LIFESTYLE HISTORY

Occupation? ____________________ **Employer?** ____________________

Do you smoke tobacco? If yes, how much per day? __________ **If you quit, when did you stop?** ______________

Do you drink alcohol? If so, how much per day? __________ **Do you take recreational drugs?** ______________

When was your last physical exam by a Doctor? __________

MEDICAL BACKGROUND (use reverse side of this form if you need additional space)

Drug Allergies (list) ____
medications and reactions
____
____

Current Medications ____
____
____