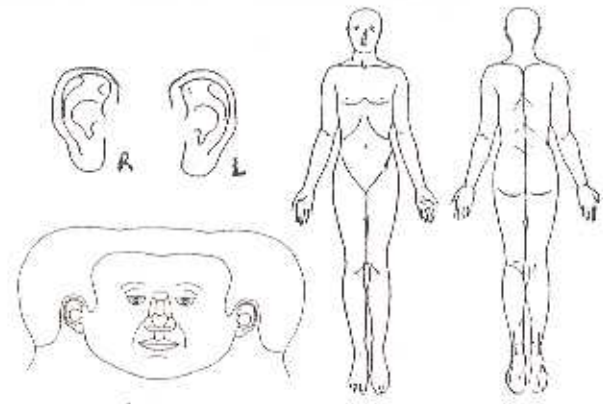


**BRIEF MEDICAL HISTORY FOR DR. ECKER**

Name: \_\_\_\_\_  
Date: \_\_\_\_\_ Age: \_\_\_\_\_  
Have we seen you before?  Yes  No  
How long ago?  Weeks  Months  Years



**PLEASE MARK THE SITE ON THE DIAGRAM**

What is your skin problem (rash, growth, acne, warts etc.)? \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_ Week(s) \_\_\_\_\_ Month(s) \_\_\_\_\_ Year(s)

Please list any treatments or medications prescribed by other doctors for this condition: \_\_\_\_\_

Please list any over-the-counter medications you have used for this condition: \_\_\_\_\_

**PLEASE CIRCLE "YES" OR "NO" AND ANSWER THE FOLLOWING:**

Are you allergic to any medicines? (penicillin, aspirin, etc.) YES NO  
If yes, please list: \_\_\_\_\_

Have you had other skin problems? (Including childhood) YES NO  
If yes, please explain: \_\_\_\_\_

Does anyone in your family have similar skin problems? YES NO  
If yes, please explain whom: \_\_\_\_\_

Have you recently (within the last year) been treated by another physician? YES NO  
Name: \_\_\_\_\_  
Reason: \_\_\_\_\_

Is there anything else I should know about your health? (such as recent surgery, diabetes, stomach ulcers, easy bleeding, etc.) YES NO  
\_\_\_\_\_

**FOR WOMEN:** Are you taking hormone or birth control pills? YES NO  
Are you nursing? YES NO  
Are you pregnant? YES NO

**FOR OFFICE USE Hx:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

Is this a referral for a new problem or from a different provider? YES NO  
If yes, whom? \_\_\_\_\_

**Treatment Notes:**