

PATIENT HEALTH INFORMATION
JACK A. DEKKINGA MD PC

Name _____ Date of Birth _____

Medications: Please provide an accurate, up to date list of your current medications:

Allergies – Please circle any of the following allergies that you are aware of:

| DRUG | FOOD | ENVIRONMENT |
|-----------------------------|-------------------|--------------------|
| ACE Inhibitors | Milk | Adhesive Tape |
| Aspirin | Nuts | Animal Dander |
| Cephalosporins | Seafood/Shellfish | Dust |
| Codeine/Codeine Derivatives | OTHER: | General |
| Local Anesthetics | | Latex |
| Neosporins | | Mites |
| NSAIDS | | Mold Spores |
| Penicillins | | OTHER: |
| Polysporin | | |
| Sulfa Drugs | | |
| Tetracyclines | | |
| Topical Antifungals | | |
| OTHER: | | |

PAST MEDICAL HISTORY

Please Circle any of the following medical conditions you have been treated for or diagnosed with in the past

| CARDIOVASCULAR | ENDOCRINE | MUSCULOSKELETAL |
|---|-----------------------------------|-------------------------------------|
| Abnormal Blood Pressure | Insulin Dependent Diabetes | Acute Arthritis |
| Anemia (chronic) | Non-insulin dependent Diabetes | Acute Juvenile Rheumatoid Arthritis |
| Arteriosclerotic Cardiovascular Disease | | Chronic Arthritis |
| Bypass Surgery | SKIN | Degenerative Joint Disease |
| Cardiac Pacemaker | Basal Cell Carcinoma | Total Hip Replacement |
| Cardiac Stent | Drug Rash | Total Knee Replacement |
| Congenital Heart Lesions | Drug Induced photosensitivity | |
| Congestive Heart Failure | Herpes Simplex (cold sores) | RESPIRATORY |
| CVA | Hyperpigmentation of skin | Acute Sinusitis |
| Heart Valve Problems | Hypopigmentation of skin | Chronic Sinusitis |
| Mitral Valve Prolapse | Keloid of Skin | Intrinsic Asthma |
| Rheumatic Heart Disease | Malignant melanoma of skin | |
| Valve Replacement | Psoriasis | INFECTIOUS DISEASE |
| | Radiation therapy for cancer/acne | Aids Related Complex |
| GASTROINTESTINAL | Skin Cancer | Gonorrhea |
| Chronic Ulcerative Colitis | Skin Lesion: Local Excision | Hepatitis |
| Common Duodenal Ulcer | Skin Lesion: Radical Excision | Herpes Genitalis |
| Gastric Ulcer | Squamous Cell Carcinoma | Syphilis |
| | Sunburn | Tuberculosis |
| NEUROLOGICAL | Ulcer of Skin | |
| Anxiety Disorder | Vascular Disease of the Skin | CANCER |
| Bipolar Disease | | Breast Cancer |
| General: | HEMATOLOGY | Leukemia |
| Parkinson's Disease | Blood Transfusions | Lung Cancer |
| Tonic-Clonic Seizures | Anemia of Chronic Disorder | Prostate Cancer |
| Vertigo | Bleeding Disorder | OTHER: |

OTHER: _____

PLEASE TURN OVER TO COMPLETE BACK SIDE ALSO – THANK YOU

SOCIAL HISTORY – Please circle the most accurate response.

| | | | | | |
|---------------|----------------------|-----------------|---------------|--------------------|---------------|
| ALCOHOL USE: | None | Occasional | Moderate | Heavy | Recently Quit |
| DRUG USE: | None | Recently Quit | Socially Only | Other: _____ | |
| TOBACCO USE: | None | How Long? _____ | Recently Quit | Would Like to Quit | Other: _____ |
| | Cigarettes ppd _____ | Pipe | Cigars | Chewing Tobacco | Snuff |
| PETS/ANIMALS: | Dog | Cat | Other: | | |

TRAVEL HISTORY: Have you recently traveled out of the country? Where? _____

Have you recently traveled within the country? Where? _____

IMMUNIZATIONS: Please circle any immunizations you are aware of having received.

| | |
|---|-----------------------------------|
| Hemophilus Influenza Type B Vaccination | Immune Globulin Hep B Vaccination |
| Hepatitis B Vaccination | Tetanus Vaccination |
| Pneumococcal Vaccination | |

PREGNANCIES: (If Applicable)

| | | |
|------------------------------------|---------------------------------|---------------------|
| Are you Pregnant? | NO | YES, DUE DATE _____ |
| How many pregnancies have you had? | 1 2 3 4 5 6 7 | Other : _____ |
| How many deliveries? | 1 2 3 4 5 6 7 | Other: _____ |

FAMILY HISTORY: Please circle any of the following in your family history and indicate which relative.

SYSTEMIC

| | | | |
|--------------------------------|--------|--------|---------|
| Arthritis | Father | Mother | Sibling |
| Asthma | Father | Mother | Sibling |
| Bleeding Disorder | Father | Mother | Sibling |
| Breast Cancer | Father | Mother | Sibling |
| Cancer | Father | Mother | Sibling |
| Colon Cancer | Father | Mother | Sibling |
| Congestive Heart Failure | Father | Mother | Sibling |
| COPD | Father | Mother | Sibling |
| Crohn's Disease | Father | Mother | Sibling |
| Hypertension | Father | Mother | Sibling |
| Hypothyroidism | Father | Mother | Sibling |
| Insulin Dependent Diabetes | Father | Mother | Sibling |
| Non-insulin Dependent Diabetes | Father | Mother | Sibling |
| Kidney Disease | Father | Mother | Sibling |
| Kidney Failure | Father | Mother | Sibling |
| Lung Cancer | Father | Mother | Sibling |
| Heart Attack | Father | Mother | Sibling |
| Seizures | Father | Mother | Sibling |
| Ulcerative Colitis | Father | Mother | Sibling |

SKIN

| | | | |
|----------------------|--------|--------|---------|
| Acne | Father | Mother | Sibling |
| Pre-Cancer | Father | Mother | Sibling |
| Basal Cell Carcinoma | Father | Mother | Sibling |
| Moles | Father | Mother | Sibling |
| Eczema | Father | Mother | Sibling |
| Melanoma | Father | Mother | Sibling |
| Psoriasis | Father | Mother | Sibling |
| Skin Cancer | Father | Mother | Sibling |
| Squamous Cell Cancer | Father | Mother | Sibling |
| Vitiligo | Father | Mother | Sibling |

By signing this form, I admit, that to the best of my knowledge, the above information is complete and accurate as of the date indicated below.

Signature _____ Date _____

In case of an emergency, who should we contact? Name: _____

Address: _____ City _____ State _____ Zip Code _____

Phone # _____ Relationship: _____