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HEALTH QUESTIONNAIRE

Name_____ Birthdate _____Preferred nickname, if any _____

How did you hear about us? _____

Referring Physician _____Other referral _____

Primary Care Provider _____ Phone _____

Preferred Pharmacy _____ Phone _____

YOU AUTHORIZE US TO LEAVE VOICEMAIL? Yes ☐ No ☐ PREFERRED MESSAGE PHONE#_____

Your authorized contact(s) name _____ Phone _____

Your authorized contact(s) name _____ Phone _____

Reason for Visit_____

All Current Medications and Dosage: Please use separate page if needed

1_____ 2_____

3_____ 4_____

5_____ 6_____

Are you allergic to any medications (include latex and anesthetics)? Yes☐ No☐

If yes, list _____

Do you take blood thinner, Aspirin, anti-inflammatory (e.g. ibuprofen, Motrin, Advil), Vit E? Yes☐ No☐

If yes, list _____

Do you take antibiotics before dental procedures? Yes☐ No☐ If yes, what antibiotic: _____

Are you prone to or have any of the following?	**YES**	**NO**	**EXPLAIN**
Diabetes	☐	☐	
Pacemaker/Defibrillator	☐	☐	
High blood pressure	☐	☐	
Artificial valve	☐	☐	
Heart disease	☐	☐	
Bleeding tendency	☐	☐	
Artificial joint	☐	☐	
Hepatitis or liver disease	☐	☐	
Kidney disease	☐	☐	
Eye problems	☐	☐	
Keloids/abnormal healing	☐	☐	
HIV or other immunodeficiency	☐	☐	
Organ transplantation	☐	☐	
Nerve damage or stroke	☐	☐	
Breathing problems (asthma/emphysema)	☐	☐	
Emotional disorders	☐	☐	
Cold Sores	☐	☐	

-PLEASE COMPLETE BOTH SIDES-

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Please list any other significant skin and medical problems _____

_____

Occupation _____

Do you smoke? Yes ☐ No ☐ How many packs/day? _____

Do you drink alcohol? Yes ☐ No ☐ How much? _____

Are you pregnant or breastfeeding? Yes ☐ No ☐

Have you had a skin cancer? Yes ☐ No ☐

If yes, type (basal cell carcinoma, squamous cell carcinoma, melanoma), treatment and date:

_____

_____

_____

Do you have a family history of melanoma? Yes ☐ No ☐

Have you had Mohs surgery before? Yes ☐ No ☐ If yes, site of surgery and surgeon:

_____

_____

Have you been diagnosed with cancer other than skin? Yes ☐ No ☐ If yes, type, date & treatment:

_____

_____

Have you had surgeries in the past? Yes ☐ No ☐ If yes, type and date:

_____

_____

Cosmetic Consultation: Please list previous cosmetic procedures (Laser, Botox, Fillers, and Surgeries)

_____

_____

_____

Additional Comments: _____

_____

_____

Patient signature _____ **Date** _____

Reviewed by/date _____ _____

_____ _____ _____