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MEDICAL DERMATOLOGY 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 _____

All current Medications and Dosage, including Supplements: (please use separate page if needed)_____

_____

Drug Allergies: Yes ☐ No ☐ if yes, please list:_____

Circle any other allergies: local anesthetics ☐ rubber/latex ☐ tape/bandages ☐ topical antibiotics ☐

Do you take a blood thinner, (aspirin, ibuprofen, Coumadin, Vit E)? Yes ☐ No ☐

If yes, list _____

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

SKIN HISTORY:

Where did you live from ages 0-18? _____

Blistering sunburns? Yes ☐ No ☐ How many? _____

Tanning bed use? Yes ☐ No ☐ How often? _____

History of skin cancer? Yes ☐ No ☐ Type: _____

Family history of skin cancer? Yes ☐ No ☐ Type: _____

History of allergies/asthma/eczema/other skin disease? _____

In family? _____

SOCIAL HISTORY:

Do you drink alcohol? _____ drinks/day _____ Do you smoke? _____ packs/day _____

Marital Status: ☐S ☐M ☐W ☐D ☐DP Pregnant? Yes ☐ No ☐ If so, what is your due date? _____

Are you breast feeding? Yes ☐ No ☐

Children and ages: _____

Occupation: _____

Hobbies: _____

For office use only

Reviewed by/date _____ _____ _____ _____ _____ _____

-PLEASE COMPLETE BOTH SIDES-

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Do you have NOW or in the PAST any of the following?	YES	NO	EXPLAIN
General symptoms (fever, chills, weight change)?	☐	☐	
Diabetes	☐	☐	
Pacemaker or Defibrillator	☐	☐	
High blood pressure	☐	☐	
Heart disease	☐	☐	
Bleeding tendency	☐	☐	
Joint problems or Artificial joint	☐	☐	
Hepatitis or liver disease	☐	☐	
Gastrointestinal disease	☐	☐	
Kidney disease	☐	☐	
Eye or vision problems	☐	☐	
Keloids or abnormal healing	☐	☐	
HIV or other immunodeficiency	☐	☐	
Nerve damage or stroke	☐	☐	
Breathing problems (asthma/emphysema)	☐	☐	
Mental Health disorders	☐	☐	
Leg swelling or varicose veins	☐	☐	
Cold Sores	☐	☐	
Cancer other than skin	☐	☐	

Other diseases/conditions/surgeries: _____

_____

_____

_____

Additional Comments: _____

_____

_____

_____

Patient signature _____ Date _____

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