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HEALTH QUESTIONNAIRE

Name_____ Birthdate_____
Home phone_____ Mobile phone_____
Occupation_____ Work phone_____
Referring Physician_____ Phone_____
Address_____
Primary Care Physician_____ Phone_____
Address_____
Pharmacy_____

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)? Please list with type of reaction.

_____

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	____	____	_____

-continued on reverse-

Please list any other significant skin and medical problems_____

_____

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 _____ _____

_____ _____ _____