PORTLAND DERMATOLOGY CLINIC LLP

1414 NW Northrup, Ste 600
Portland, Oregon 97209
ph: 503 223-3104 **fx**: 503 223-4619
www.portlanddermclinic.com

HEALTH QUESTIONNAIRE

Patient name _____ Preferred nickname, if any _____

Birthdate _____ How did you hear about us? _____

Address _____ Gender ❑Female ❑ Male

City _____ State _____ Zip code _____

Please list the phone number(s) and email where we can reach you indicating primary contact and if ok to leave a message:

Cell		Primary ❑ Message ❑	**Home**		Primary ❑ Message ❑
Work		Primary ❑ Message ❑	**Other**		Primary ❑ Message ❑
Email		Primary ❑	**May we send you announcements and our newsletter?** ❑ Yes, by email ❑ Yes, by postal mail ❑ No		

Please list any other contacts we can speak to in case of emergency, regarding your health or your account:

Emergency Contact _____ Relationship to patient _____ Phone _____

Authorized Contact _____ Relationship to patient _____ Phone _____

Referring physician: _____ Phone: _____

Primary care provider: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

	Skin History	Year	Details
❑	- No significant skin history		
❑	>3 blistering sunburns or tanning bed use		
❑	Basal Cell Carcinoma		
❑	Squamous Cell Carcinoma		
❑	Abnormal mole		
❑	Melanoma		
❑	Family history of Melanoma		

	Medical History	Details
❑	- No Pertinent Past Medical History	
❑	Artificial heart valve	
❑	Asthma or emphysema	
❑	Bleeding tendency	
❑	Blood clot	
❑	Cancer (other than skin)	
❑	Cold sores	
❑	Depression or anxiety	
❑	Diabetes	

❑	Eye or vision problems	
❑	Gastrointestinal Illness	
❑	Hay fever (seasonal allergies)	
❑	Heart Disease	
❑	High Blood Pressure	
❑	High Cholesterol	
❑	History of staph infection	
❑	HIV	
❑	Joint problems or artificial joint	
❑	Keloids or abnormal healing	
❑	Kidney disease	
❑	Leg swelling or varicose veins	
❑	Liver disease or hepatitis	
❑	Neurologic disorder	
❑	Organ Transplant	
❑	Pacemaker / Defibrillator	
❑	Radiation Therapy	
❑	Stroke	
❑	Thyroid Disorder	
❑	Other History	

	Surgical History	**Details**
1		
2		
3		

	Allergies (if none, please write none)		**Do you have a reaction to any of the following?**	
	Medication	**Reaction**	❑	No reactions to any of following
1			❑	Local anesthetics (ex. lidocaine)
2			❑	Rubber/latex
3			❑	Topical antibiotics (ex. neosporin)
4			❑	Surgical tape/bandages

	Current Medications (if none, please write none)			
	Medication Name	**Dosage**	**# of times daily**	**Details**
1				
2				
3				
4				

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5				
6				
7				
8				
	If you require additional lines- please bring a list			

Do you take blood thinners (aspirin, ibuprofen/Motrin/Advil, Vit E)? ❑ Yes ❑ No
Do you take antibiotics before dental procedures? ❑ Yes ❑ No
If yes, what antibiotic? _____

Have you received a flu shot this year? If yes, please select where:	❑ Vaccinated at doctor's office or pharmacy ❑ Vaccinated at time of surgery ❑ Vaccinated at hospital ❑ Vaccinated at work	Have you ever received a vaccine for pneumonia (Pneumovax)?	❑ Yes ❑ No
Reason for not receiving a flu shot:	❑ Not vaccinated due to allergy to eggs ❑ Not vaccinated due to allergy to Influenza vaccine ❑ Not vaccinated, reason not given ❑ Declined vaccination		

Social history		**Personal Habits**	
Marital Status:	❑ Single ❑ Widowed ❑ Married ❑ Domestic partner ❑ Divorced	Alcohol Use:	❑ Never drink alcohol ❑ Occasionally drink alcohol ❑ Drink alcohol daily
Occupation:		Tobacco Use:	❑ Current every day smoker ❑ Current some day smoker ❑ Former smoker ❑ Never smoker ❑ Smoker, current status unknown ❑ Unknown if ever smoked ❑ Heavy tobacco smoker ❑ Light tobacco smoker Date Started: _____ Date Ended: _____
Hobbies:			
Where did you live from age 0-18?			
Children and ages:			
Are you currently pregnant? Breastfeeding?	❑ Yes ❑ No ❑ Yes ❑ No		
Do you consider yourself Hispanic or Latino?	❑ Yes ❑ No ❑ Declined		
Which category best describes your race?	❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Decline		

Patient or legal guardian signature **Date**