HEALTH QUESTIONNAIRE

Name ______________________________ Age: ________

Occupation: ______________________ Name of referring doctor: ______________________

Why are you seeing the dermatologist today? ______________________

Prior treatments used for it? ______________________

What part(s) of your body is (are) affected? ______________ Have you had it before? ________

How long have you had it? ________ Does it bleed? ______________

Does it Itch / Hurt? ______________________

Do you want a full skin exam today? ________

List all current medications (including non-prescription, vitamins, and aspirin)

Name of drug / Dosage / Frequency

______________________ ______________________

______________________ ______________________

______________________ ______________________

List all medication ALLERGIES: ______________________ Check if none ☐

List major surgeries/illness:

______________________ ______________________

______________________ ______________________

Personal Medical History: (check all that apply)

☐ Pacemaker/defibrillator
☐ High blood pressure
☐ Heart murmur
☐ Artificial heart valve
☐ Asthma
☐ Cancer (not skin)
☐ Anemia
☐ Artificial Joint
☐ Gout/Arthritis
☐ Thyroid problems
☐ Diabetes
☐ Other (specify) ______________________
☐ Hepatitis
☐ Depression
☐ HIV/AIDS

Habits: Alcohol (amount per week) ______________ Tobacco (amount per day) ______________

Past Personal skin problems: (check all that apply)

☐ Abnormal moles
☐ Melanoma
☐ thick scars or keloid
☐ Eczema or dermatitis
☐ Psoriasis
☐ Acne
☐ Skin cancer
☐ Other (specify) ______________

Family history of skin disease: (check all that apply)

☐ Abnormal moles
☐ Melanoma
☐ Keloid scars
☐ Eczema or dermatitis
☐ Psoriasis
☐ Skin cancer
☐ Cancer (not skin)
☐ Other (specify) ______________

Women only: Are you pregnant? ________ Trying to become pregnant? ________ Breast Feeding? ________

Are your menstrual cycles regular? ______________ Birth control method? ______________

Signature ______________________ Date: ______________

Reviewed by: ______________________