



## Patient History Questionnaire

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

### PAST MEDICAL HISTORY: PLEASE INDICATE ANY CONDITIONS THAT YOU HAVE OR HAVE HAD IN THE PAST:

#### Critical Information

- Melanoma
- Basal cell carcinoma
- Squamous cell carcinoma
- Atypical Moles
- Precancerous skin lesions (AK)
- Pacemaker/Defibrillator
- Anticoagulant therapy  
(Aspirin, Plavix, Coumadin)
- Artificial joints
- Artificial heart valve
- Diabetes
- Chemotherapy-current
- Hepatitis B
- Hepatitis C
- HIV/AIDS
- Latex allergy
- Polysporin/Neosporin allergy
- Adhesive allergy
- Organ transplant
  - Kidney
  - Heart
  - Liver
  - Lung

#### Dermatology Information

- Allergy-skin
- Easy bruising/bleeding
- Eczema
- Herpes zoster (shingles)
- Herpes (genital)
- Herpes (oral)
- History MRSA-staph infection
- Keloid/thick scars
- Psoriasis
- other skin disease

#### Medical Surgical Information

- Anemia
- Arthritis
  - Rheumatoid
  - Psoriatic
  - Osteoarthritis
- Autoimmune disease
  - Lupus
  - Fibromyalgia
  - Dermatomyositis
  - Sjogren's disease
  - Scleroderma
- Heart disease
  - Angina (chest pain)
  - Congestive heart failure
  - Heart attack
  - Heart murmur
  - Open heart surgery
  - Hypertension
  - Irregular heart rhythm
  - High cholesterol/triglycerides
- Kidney disease
  - Renal failure
  - Dialysis
- Liver disease
  - Cirrhosis
  - Liver failure
- Lung disease
  - Asthma
  - Emphysema (COPD)
- Psychiatric disorder
  - Depression
  - OCD
  - Anxiety
- Seizures
- Stroke

#### Medical/Surgical Information (cont'd)

- Stomach/intestinal disorders
  - Stomach ulcer
  - Crohn's disease
  - GERD
  - Irritable bowel disease
  - Ulcerative colitis
- Thyroid disease
- Tuberculosis
- Venereal disease
- Other medical/surgical history

#### Cancer History

- Non-skin cancer (type)

For females:

Are you pregnant or breastfeeding?

Yes  No

Are you planning pregnancy in the next 6 months?

Yes  No

Over →

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**FAMILY HISTORY: PLEASE INDICATE ANY OF THE FOLLOWING CONDITIONS IN YOUR FAMILY:**

	Mother	Father	Sibling	Child
Atypical moles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non melanoma skin cancer (Basal cell or squamous cell carcinoma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, eczema or hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SOCIAL HISTORY:**

- Do you use alcohol?  Yes  No  
Do you use tobacco?  Yes  No  
Do you use recreational drugs?  Yes  No  
Do you use sunscreen regularly?  Yes  No  
Do you use a tanning bed?  Yes  No  
Do you work outdoors?  Yes  No

**FREQUENCY:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
SPF# \_\_\_\_\_  
\_\_\_\_\_

Do you live:  alone  with spouse/partner  with roommate/other

Occupation: \_\_\_\_\_

Hobbies/Leisure: \_\_\_\_\_

**REVIEW OF SYSTEMS: Are you experiencing any of the following:**

- Fatigue  Weight loss  Rash/itch  Nausea  
 Fever  Joint pain  Shortness of breath  Vomiting  
 Night sweats  Headache  Wheezing  Diarrhea

**DEAR PATIENT:**

Because of the alarming rise in the number of skin cancers in the last 10 years, the American Academy of Dermatology recommends a complete examination of the skin. Fortunately, cancer of the skin is usually curable when found and treated early. We will provide an examination gown if this full exam is desired. Please indicate your intentions below.

Please check one:

- Yes, I would like the complete exam.  
 No, I would not like the complete exam.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_