Patient History Questionnaire

Patient Name: ______________________ Date: ____________ DOB: ____________

Reason for Visit: ______________________

Current Medications: ______________________

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Medication Allergies: ______________________

Smoking status: ☐ never smoker ☐ former smoker ☐ current smoker ________ pack(s) per day

Have you had a pneumonia vaccine this year? ☐ yes ☐ no

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

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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

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Cancer History

- ☐ Non-skin cancer (type)

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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	☐	☐	☐	☐
Melanoma	☐	☐	☐	☐
Non melanoma skin cancer (Basal cell or squamous cell carcinoma)	☐	☐	☐	☐
Asthma, eczema or hay fever	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐

SOCIAL HISTORY:			**FREQUENCY:**
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	SPF# ____________________________
Do you use a tanning bed?	☐ Yes	☐ No	________________________________
Do you work outdoors?	☐ Yes	☐ No	________________________________

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: ____________________