

## Medical History Questionnaire

(Please fill in all circles completely)

Name: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Who were you referred by? \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

Are you allergic to any medications? (If yes, list meds and reactions below)  Yes

\_\_\_\_\_

Have you ever had a reaction to Novacaine, lidocaine, bandages, latex, or topical antibiotics (neosporin)  Yes

If yes, describe:

\_\_\_\_\_

Please list below current medications you are taking (including prescriptions, over the counter meds, vitamins, herbal supplements):

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**Have you ever had a history of:**

I have no history of significant medical problems

Yes

Emphysema/COPD  Yes  
 Asthma  Yes  
 Depression or Anxiety  Yes  
 Seasonal Allergies/Hayfever  Yes  
 High Blood Pressure  Yes  
 Heart Failure  Yes  
 Heart Attack  Yes  
 Mitral Valve Prolapse  Yes  
 Irregular Heartbeat  Yes  
 Pacemaker  Yes  
 Fainting  Yes

Diabetes  Yes  
 Thyroid Disease  Yes  
 Kidney Disease/Failure  Yes  
 Arthritis  Yes  
 Liver Disease  Yes  
 HIV/AIDS  Yes  
 Lupus  Yes  
 Convulsions, Epilepsy, Seizures  Yes  
 Cancer (type: \_\_\_\_\_)  Yes  
 Joint Replacement  Yes  
 History of Blood Transfusions  Yes

List any other diseases or condition: \_\_\_\_\_

### Dermatologic History

Skin Cancer (type unknown)  Yes  
 Melanoma  Yes  
 Atypical/dysplastic moles  Yes  
 Squamous Cell Carcinoma  Yes  
 Basal Cell Carcinoma  Yes  
 Actinic Keratosis  Yes  
 History of keloids  Yes  
 Psoriasis  Yes  
 Atopic Dermatitis  Yes  
 Hives  Yes

### Family Dermatologic History

None  
 Melanoma  
 Atypical/dysplastic moles  
 Squamous cell cancer  
 Basal cell cancer  
 Actinic keratosis  
 Unknown skin cancer  
 Psoriasis  
 Atopic Dermatitis

### Social History

Have you had more than one severe sunburn?  Yes  
 Do you or have you ever used a tanning bed?  Yes  
 Do you use sunscreen?  Yes  
 Do you now or have you ever used alcohol?  Yes  
 Do you now or have you ever use tobacco?  Yes  
 Do you use any drugs (including marijuana)?  Yes  
 Have you traveled outside the US in the last 3 months?  Yes

### Review of Systems

Fevers/Chills  Yes Irregular periods  Yes  
 Weight loss  Yes Oral/patch contraceptives  Yes  
 Loss of appetite  Yes Pregnant  Yes  
 Night sweats  Yes Trying to conceive  Yes  
 Joint Aches  Yes Breastfeeding  Yes  
 Photosensitivity  Yes PCOS  Yes  
 Easy bleeding/bruising  Yes  
 Shortness of breath  Yes  
 Cough  Yes  
 Nausea/vomiting/diarrhea  Yes  
 Abdominal Pain  Yes  
 Chest Pain  Yes  
 Headache/migraines  Yes  
 Vision changes  Yes