

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 (neospirin) 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 a history of significant medical problems No / Yes

Emphysema/COPD	<input type="radio"/> No / Yes	Diabetes	<input type="radio"/> No / Yes
Asthma	<input type="radio"/> No / Yes	Thyroid Disease	<input type="radio"/> No / Yes
Depression or Anxiety	<input type="radio"/> No / Yes	Kidney Disease/Failure	<input type="radio"/> No / Yes
Seasonal Allergies/Hayfever	<input type="radio"/> No / Yes	Arthritis	<input type="radio"/> No / Yes
High Blood Pressure	<input type="radio"/> No / Yes	Liver Disease	<input type="radio"/> No / Yes
Heart Failure	<input type="radio"/> No / Yes	HIV/AIDS	<input type="radio"/> No / Yes
Heart Attack	<input type="radio"/> No / Yes	Lupus	<input type="radio"/> No / Yes
Mitral Valve Prolapse	<input type="radio"/> No / Yes	Convulsions, Epilepsy, Seizures	<input type="radio"/> No / Yes
Irregular Heartbeat	<input type="radio"/> No / Yes	Cancer (type: _____)	<input type="radio"/> No / Yes
Pacemaker	<input type="radio"/> No / Yes	Joint Replacement	<input type="radio"/> No / Yes
Defibrillator	<input type="radio"/> No / Yes	History of Blood Transfusions	<input type="radio"/> No / Yes
Fainting	<input type="radio"/> No / Yes		

List any other diseases or condition: _____

Dermatologic History

Skin Cancer (type unknown)	<input type="radio"/> No / Yes
Melanoma	<input type="radio"/> No / Yes
Atypical/dysplastic moles	<input type="radio"/> No / Yes
Squamous Cell Carcinoma	<input type="radio"/> No / Yes
Basal Cell Carcinoma	<input type="radio"/> No / Yes
Actinic Keratosis	<input type="radio"/> No / Yes
History of keloids	<input type="radio"/> No / Yes
Psoriasis	<input type="radio"/> No / Yes
Atopic Dermatitis	<input type="radio"/> No / Yes
Hives	<input type="radio"/> No / 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?	<input type="radio"/> No / Yes
Do you or have you ever used a tanning bed?	<input type="radio"/> No / Yes
Do you use sunscreen?	<input type="radio"/> No / Yes
Do you now or have you ever used alcohol?	<input type="radio"/> No / Yes
Do you now or have you ever use tobacco?	<input type="radio"/> No / Yes
Do you use any drugs (including marijuana)?	<input type="radio"/> No / Yes
Have you traveled outside the US in the last 3 months?	<input type="radio"/> No / Yes

Review of Systems

Fevers/Chills	<input type="radio"/> No / Yes	Irregular periods	<input type="radio"/> No / Yes
Weight loss	<input type="radio"/> No / Yes	Oral/patch contraceptives	<input type="radio"/> No / Yes
Loss of appetite	<input type="radio"/> No / Yes	Pregnant	<input type="radio"/> No / Yes
Night sweats	<input type="radio"/> No / Yes	Trying to conceive	<input type="radio"/> No / Yes
Joint Aches	<input type="radio"/> No / Yes	Breastfeeding	<input type="radio"/> No / Yes
Photosensitivity	<input type="radio"/> No / Yes	PCOS	<input type="radio"/> No / Yes
Easy bleeding/bruising	<input type="radio"/> No / Yes		
Shortness of breath	<input type="radio"/> No / Yes		
Cough	<input type="radio"/> No / Yes		
Nausea/vomiting/diarrhea	<input type="radio"/> No / Yes		
Abdominal Pain	<input type="radio"/> No / Yes		
Chest Pain	<input type="radio"/> No / Yes		
Headache/migraines	<input type="radio"/> No / Yes		
Vision changes	<input type="radio"/> No / Yes		