DERMATOLOGY
+AESTHETICS
HEALTH SKIN BEAUTY

Medical History Questionnaire

(Please fill in all circles completely)

Name: _____ Date of Birth: ___/___/_____ Date: ___/___/_____

Who were you referred by? _____ Occupation: _____

What is the reason for today's visit? _____

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

_____

Have you ever had a reaction to Novacain, lidocaine, bandages, latex, or topical antibiotics (neosporin)? O Yes
If yes, describe: _____

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

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Pharmacy Name: _____ Pharmacy Number or Intersection/Location: _____

Have you ever had a history of:

Emphysema/COPD	No/Yes
Asthma	No/Yes
Depression or Anxiety	No/Yes
Seasonal Allergies/Hayfever	No/Yes
High Blood Pressure	No/Yes
Heart Failure	No/Yes
Heart Attack	No/Yes
High Cholesterol	No/Yes
Mitral Valve Prolapse	No/Yes
Irregular Heartbeat	No/Yes
Pacemaker	No/Yes
Defibrilator	No/Yes
Fainting	No/Yes

I have a history of significant medical problems No/Yes

Diabetes	No/Yes
Thyroid Disease	No/Yes
Kidney Disease/Failure	No/Yes
Arthritis	No/Yes
Liver Disease	No/Yes
HIV/AIDS	No/Yes
Myasthenia Gravis	No/Yes
Lupus	No/Yes
Convulsion, Epilepsy, Seizures	No/Yes
Cancer (type: _____)	No/Yes
Joint Replacement	No/Yes
History of Blood Transfusions	No/Yes

List of any other diseases or condition: _____

Dermatologic History

Skin Cancer (type unknown)	No/Yes
Melanoma	No/Yes
Atypical/Dysplastic Moles	No/Yes
Squamous Cell Carcinoma	No/Yes
Basal Cell Carcinoma	No/Yes
Actinic Keratosis	No/Yes
History of Keloids	No/Yes
Psoriasis	No/Yes
Atopic Dermatitis	No/Yes
Hives	No/Yes
HSV or Cold Sores	No/Yes

Family Dermatologic History

O None
O Melanoma
O Atypical/dysplastic moles
O Squamous Cell Carcinoma
O Basal Cell Carcinoma
O Actinic Keratosis
O Unknown Skin Cancer
O Psoriasis
O Atopic Dermatitis

Social History

Have you had more than one severe sunburn?	No/Yes
Do you or have you ever used a tanning bed?	No/Yes
Do you use sunscreen?	No/Yes
Do you now or have you ever used alcohol?	No/Yes
Do you now or have you ever used tobacco?	No/Yes
If so, current or former use? _____	
Do you use any drugs (including marijuana)?	No/Yes
Have you traveled outside the US in the last 3 months?	No/Yes

Review of Symptoms

Fever/Chills	No/Yes	Irregular Periods	No/Yes
Weight Loss	No/Yes	Oral/Patch contraceptives	No/Yes
Loss of Appetite	No/Yes	Pregnant	No/Yes
Night Sweats	No/Yes	Trying to conceive	No/Yes
Joint Aches	No/Yes	Breastfeeding	No/Yes
Photosensitivity	No/Yes	PCOS	No/Yes
Easy bleeding/bruising	No/Yes	Shortness of Breath	No/Yes
Cough	No/Yes	Nausea/vomiting/diarrhea	No/Yes
Abdominal Pain	No/Yes	Chest Pain	No/Yes
Headaches/migraines	No/Yes	Vision Changes	No/Yes