The
Dermatology
Clinic PLLC

Patient Questionnaire

Please answer the following questions (please print)

Name____________________________________ DOB _____/______/________ Today's Date____/_____/_______

Reason for today's visit____
____
How long have you had this problem?____
List Any Previous Treatment for the problem____
____
Please list all Allergies (medication or other)____
List all Medications you are currently taking (prescriptions or over-the-counter meds; including Aspirin, Vitamins and herbals/Dosage and Frequency)____
____
Have you had extensive sun exposure? (Even as a child) __Yes __No
Have you had blistering sunburns? (Even as a child) __Yes __No
Do you have a history of Skin Cancer? __Yes __No Type____
If yes, please list ***site, date, treatment and Doctor***.____
____
Please list any other cancers or malignancies______________ ____
____
Please check if you have had: ____ Psoriasis ____Eczema ____Acne
Do you require pre-op antibiotic treatment____
List all surgical procedures and year performed (within the last 10 years) ___________________________ _____________
____
Please check if **family member** has had any of these diseases and list family member.

__ Melanoma Family member____________
__ Other Skin cancer Family member____________
__ Seasonal Allergies Family member____________
__ Psoriasis Family member____________
__ Eczema Family member____________
__Acne Family member____________
__other_____________________________________

Do you smoke? ___ Yes ___ No
Do you drink alcohol? ____Never ___ Occasionally ___ Frequently
What is your occupation (or past occupation if retired)?____

Please check any of the following problems **you** might have or had:

Skin
___keloids
___poor healing
___other________

Hematologic/Lymphatic
____anemia
____bleeding problems
____enlarged lymph nodes

General Symptoms
____weight loss
____fever
____weak, tired
____nausea, vomiting, diarrhea (when taking antibiotics)

Ears/Eyes/Nose/Throat
____glaucoma
____hearing aid
____cosmetic surgery
____other_____________

Cardiovascular
__angina, heart attacks
__heart valve problems
__pace maker/defibrillator
__high blood pressure

Respiratory
__asthma
__emphysema
__other lung problems
__allergies

Gastrointestinal
__stomach ulcers
__other GI problems

Musculoskeletal
__arthritis
__artificial joints
__aching joints
__other_____________

Neurological
__Stroke
__seizures
__other_______________

Psychiatric
__depression
__anxiety attacks
__other_____________

Endocrine
__diabetes
__thyroid problems
__other_______________

Infections
__hepatitis __TB
__urinary tract
__HIV/AIDS
__Staph

Have you ever had dental anesthesia (Novocaine)? __Yes __No Any bad reaction? __Yes __No

Patient Signature____

Signed by Physician___________________________ **Reviewed by** _____________________