MEDICAL QUESTIONAIRE

Name________________________________ Date of Birth________________ Age______

Referred by: Dr. (name)________________________ Family member (name)______________________

Friend (name)________________________ Yellow pages____________________

Newspaper________________________ Other____________________

Medical History:

Reason for visit: ____

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How long have you had this problem: ____

Symptoms (how does it bother you?): ____

Treatments you have tried: ____

Please list **all medications** your are currently taking (include over-the-counter): ______________________

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Please list any **drugs you are allergic** to: ____

Medical problems (mark if yes) ☐ Diabetes ☐High blood pressure ☐Heart disease ☐Pacemeker

☐Artificial joint/valve ☐Asthma ☐other Lung disease ☐Thyroid disease ☐Anemia

☐Hepatitis, type____ ☐HIV ☐other Liver disease ☐Lupus ☐Kidney disease

☐Cancer, type____ ☐Depression ☐History of long-term steroid use ☐X-Ray therapy

☐Other (comments) ____

Past Surgeries/Medical problems ____

Pregnant? ☐yes ☐no (__________weeks, # previous pregnancies______________)

History of Skin Cancer? Yes or No: ☐Melanoma ☐Basal cell carcinoma ☐Squamous cell carcinoma

Area of body____________________________ How treated?____________________________

History of Skin Disease, past or current ____

When you are exposed to sunlight, do you (Check most applicable one):

1. ___ always burn
2. ___ usually burn, rarely tan
3. ___ often burn, tan slowly
4. ___ sometimes burn, tan well
5. ___ rarely burn, always tan
6. ___ never burn, deeply tan

Review of Systems (please mark which of the following symptoms you are currently having)

☐Prone to infection ☐Vision ☐Hearing ☐Stuffy Nose

☐Weight change ☐Eyelid scale ☐Dizziness ☐Sinus pain

☐Fever/sweats ☐Faint ☐Mouth sore/throat pain

☐Chest pain ☐Shortness of breath ☐Nausea/vomiting ☐Penile/vaginal pain

☐Palpitations ☐Cough/wheezing ☐Abdomen pain ☐Penile/vaginal discharge

☐Bowel change ☐Menstrual irregularity

☐Lymph node swelling ☐Weakness of body part ☐Joint/muscle pain ☐Painful urination

☐Easy bleeding ☐Numbness of body ☐Back pain ☐Change in urination freq.

☐Blood clots ☐Seizures ☐Headaches ☐Other______________

☐Rash ☐Itchy skin ☐Skin growths ☐Bad scars (keloids)

☐Dry skin ☐Skin sores ☐Hair/nail problems ☐Skin color changes

Past Family and Social History:

Is there a family history of (please circle): melanoma, skin cancer, asthma, eczema, hay fever, psoriasis, hair loss, diabetes, adult acne, genetic diseases? Other____

Patient occupation____________________ Hobbies______________________________

Animals in the home? ____

If smoker, how many packs/day for ? years______________________________________

Number of alcoholic drinks per week ________________________

History of past IV drug abuse, blood transfusions, or unprotected intercourse: Yes or No

Reviewed by M.D.,

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