Medical Dermatology Questionnaire

Printed Patient Name: ___________________________________ Date of Birth: ____________
Reason for Visit: ____ Today's Date: ____________
Address: ______________________________City:_____________ State: ______Zip: _________
Email: ____Preferred Phone: ______________

HOW DID YOU LEARN ABOUT US?	REFERRAL NAME
Primary Care Provider	
Another dermatologist	
Family/Friend/Co-Worker	
Other (Specify)	

CURRENT MEDICATIONS: (Include vitamins, supplements, and over the counter medications)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

MEDICATION ALLERGIES: No known allergies _______ If yes, complete below

Name of Medication	Type of reaction			
	Rash	difficulty breathing	stomach pain/vomiting	other
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MEDICAL HISTORY: PLEASE CHECK OR FILL IN ALL *DIAGNOSED* MEDICAL CONDITIONS

Skin Cancer	Immunological Disease:
Melanoma:	Immune Deficiency
Date:	HIV/AIDS
Location:	Lupus or Scleroderma
Squamous Cell Carcinoma:	Rheumatological Disease
Date:	Osteoarthritis
Location:	Rheumatoid Arthritis
Basal Cell Carcinoma:	Gout
Date:	Psychological/Emotional Disease:
Location:	Depression
Actinic Keratosis (pre skin cancer):	Obsessive/Compulsive
Date:	Gastrointestinal Disease:
Location:	Crohn's Disease, Ulcerative Colitis
Other:	Esophageal Reflux
Date:	Peptic Ulcer
Location:	Esophagitis
Dermatological Disease:	Cardiovascular Disease:
Herpes/Cold Sores	High Blood Pressure
Psoriasis	Heart Problems
Eczema	Heart Attack: Date:
Acne/Rosacea	Pacemaker/AICD
Blistering disorder:	Irregular Heart Beat
Healing Problems: slow keloid bruising	High Cholesterol

Hematology/Oncology	Endocrine Disease:
Cancer: Type:	Diabetes
Bleeding Problems	Hyperthyroid/Hypothyroid
Neurological Disease:	Liver Disease:
Stroke/ Aneurysm	Hepatitis: Type:
Seizure/Epilepsy	Jaundice
Alzheimer's	Lung Disease:
Fainting	Asthma
Kidney Disease	COPD
Poor Functioning Kidneys	Tuberculosis
Dialysis: Type:	Others Not Listed:
For Female Patients:	
Are you pregnant? Yes No	
Are you planning a pregnancy? Yes No	
Polycystic Ovarian Disease	
Breastfeeding? Yes No	

SURGERIES

Type of surgery	Surgeon	Hospital	Date

FAMILY MEDICAL HISTORY: (PLEASE ADD ANY OTHERS NOT LISTED)

Conditions/Problems	Family members affected and exact nature of problem
Melanoma	
Non-Melanoma Skin Cancer	
Blistering Disorder	
Auto-Immune Disorder	
Psoriasis	
Other	

SOCIAL HISTORY/HABITS

Occupation:	Active Retired
Smoker: Yes No	Packs per day Quit/Date
Smokeless Tobacco: Yes No	
Alcohol: Yes No	If yes # of drinks per week
Recreational Drug Use: Yes No	If yes, what type?
Sunscreen Use:	Daily Rarely Never
Outdoor Activity:	
Travel outside the USA in past 3 months?	Yes No Is yes, where?
Tanning bed use? Yes No	If yes, how often? How many years?

Patient Printed Name: ____ Date: _______________

Patient signature: ____