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HEALTH HISTORY QUESTIONNAIRE

DATE _____/_____/_____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:	☐ M ☐ F	DOB____/____/____

Height:	Weight:	Referring Physician:

PRESENT DERMATOLOGY HEALTH CONCERN(S)

Please describe your current dermatology/skin problem(s) and why you are seeking consultation.

ILLNESSES (Please check all that apply)

Have you ever been diagnosed with any of the following illnesses or medical problems? If yes, please include approximate date or year.

☐ Pacemaker/Defibrillator	Date/Yr:	☐ Paget's Disease	Date/Yr:
☐ Diabetes	Date/Yr:	☐ Colon Cancer	Date/Yr:
☐ Coronary Artery Disease	Date/Yr:	☐ Breast Cancer	Date/Yr:
☐ Heart Attack	Date/Yr:	☐ Bladder/Kidney Cancer	Date/Yr:
☐ Angina	Date/Yr:	☐ Prostate Cancer	Date/Yr:
☐ Heart Failure	Date/Yr:	☐ Lung Cancer	Date/Yr:
☐ Mitral Valve Prolapse	Date/Yr:	☐ Cervical/Ovarian Cancer	Date/Yr:
☐ Stroke/Transient Ischemic Attack	Date/Yr:	☐ Parkinson's Disease	Date/Yr:
☐ Deep Venous Thrombosis	Date/Yr:	☐ Alzheimer's Disease	Date/Yr:
☐ High Blood Pressure	Date/Yr:	☐ Multiple Sclerosis	Date/Yr:
☐ Artificial Heart Valve	Date/Yr:	☐ Seizures	Date/Yr:
☐ Cardiac Arrhythmia	Date/Yr:	☐ Genital Condyloma	Date/Yr:
☐ Heart Murmur	Date/Yr:	☐ Genital Herpes	Date/Yr:
☐ HIV/AIDS	Date/Yr:	☐ Serious Infection/Sepsis	Date/Yr:
☐ Hepatitis - Type:	Date/Yr:	☐ Anemia	Date/Yr:
☐ Leukemia	Date/Yr:	☐ Shortness of Breath	Date/Yr:
☐ Non-Hodgkin's Lymphoma	Date/Yr:	☐ COPD	Date/Yr:
☐ C. Difficile Colitis	Date/Yr:	☐ Emphyzema	Date/Yr:
☐ Renal/Kidney Disease	Date/Yr:	☐ Asthma/Bronchitis	Date/Yr:
☐ Liver Disease	Date/Yr:	☐ Thyroid Disease	Date/Yr:
☐ Artificial Joint	Date/Yr:	☐ Blood Transfusion	Date/Yr:
☐ Covid-19	Date/Yr:	☐ Hodgkin's Disease	Date/Yr:
☐ Melanoma	Date/Yr:	☐ Rheumatologic Disease	Date/Yr:
☐ Basal Cell Carcinoma	Date/Yr:	☐ Lupus	Date/Yr:
☐ Squamous Cell Carcinoma	Date/Yr:	☐ Psoriasis	Date/Yr:
☐ Merkel Cell Cancer	Date/Yr:	☐ Eczema	Date/Yr:
☐ Atypical Nevi	Date/Yr:	☐ Severe Acne	Date/Yr:
☐ Radiation Treatment for Acne	Date/Yr:	☐ Blistering Sunburns	Date/Yr:
☐ Keloid/Hypertrophic Scaring	Date/Yr:	☐ Anxiety	Date/Yr:

OPERATIONS

Please list all surgeries including approximate date or year.

Surgery	Diagnosis	Date/Year

MEDICATIONS

Please list your prescribed drugs and over-the-counter drugs, such as vitamins and nutritional supplements including approximate start date.

Name of Drug	Strength	Frequency Taken	Start Date/Year

ALLERGIES

Please list all drug allergies including type reaction. ☐ **No Drug Allergies**

Name of Drug	Reaction

FAMILY HEALTH HISTORY

☐ **No History of Familial Disease**

Relative (i.e. Father, Mother, Sister, Brother, etc.)	Illness (i.e. Skin Cancer, Diabetes, Heart Disease, etc.)

Advance Directive	☐ **None**	☐ **Living Will**	☐ **Surrogate**	
Alcohol Use	☐ **None**	☐ **Drinks/weekly**	**Duration/years**	**Date Discontinued**
Tobacco Use **Marijuana Use**	☐ **None**	☐ **Cigarettes (packs/day)**	**Duration/years**	**Date Discontinued**

CERTIFICATION

The above information is true to the best of my knowledge.

Patient/Legal Guardian/Authorized Person (Signature)	Relationship If Other Than Patient
X	

MD Signature_____ **Date Reviewed:**_____