

# Medical History Questionnaire

Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

Are you allergic to any medications? (If yes, list meds and reactions below) Yes or No

Are you Pregnant? Yes or No

Have you ever had a reaction to Novacaine, Lidocaine, bandages, or topical antibiotics (Neosporin)? Yes or No If yes, please list above

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

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

Have you had surgery or have been hospitalized in the past? If yes, please list: \_\_\_\_\_

Have you ever had skin cancer surgery? Yes or No

Please list any chronic medical conditions for which you are currently being treated: \_\_\_\_\_

## General/Dermatology

Melanoma	Yes or No
Atypical moles	Yes or No
Dysplastic moles	Yes or No
Squamous Cell Carcinoma	Yes or No
Basal Cell Carcinoma	Yes or No
Actinic Keratosis	Yes or No
Skin Cancer (type unknown)	Yes or No
Chronic Skin Disease	Yes or No
History of keloid / scarring	Yes or No
Bleeding easily	yes or No
HIV	Yes or No

## Social History

have you had more than one severe sunburn?	Yes or No
what is your occupation? _____	
what is your hobby? _____	
Do you have significant occupational sun exposure?	Yes or No
Do you use a tanning bed?	Yes or No
Do you use sunscreen?	Yes or No
Have you been exposed to HEP A, B, C, D?	Yes or No
Have you been exposed to HIV?	Yes or No
Do you now or have you ever used alcohol?	Yes or No
Do you now or have you ever used tobacco?	Yes or No
Do you use any drugs (including marijuana)?	Yes or No
Have you traveled outside the US in the last 3 months?	Yes or No

## Have you ever had a history of?

Bronchitis	Yes
Emphysema	Yes
Asthma	Yes
Chronic Cough	Yes
Morning Cough	Yes
Shortness of Breath	Yes
Wheezing	Yes
High Blood Pressure	Yes
Chest Pain	Yes
Heart attack	Yes
Irregular Heartbeat	Yes
Phlebitis	Yes
Inflammation of vein	Yes
Blood Clots	Yes
Pacemaker	Yes
Fainting	Yes

Diabetes	Yes
Excessive Thirst/Hunger	Yes
Amputation	Yes
Thyroid Disease	Yes
Kidney Disease/Failure	Yes
Dialysis	Yes
Urinary Tract Infection	Yes
Stomach absorptive disorder	Yes
Nausea, vomiting, diarrhea	
when taking antibiotics	Yes
Yeast infection when taking antibiotics	Yes
Arthritis/Joint Deformity	Yes
Arthralgia	Yes
Limited Motion	Yes
Artificial Joint	Yes
Convulsions, Epilepsy, Seizures	Yes

## Family History of Skin Cancer

Mother	<input type="checkbox"/> None	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Atypical Moles	<input type="checkbox"/> SCC	<input type="checkbox"/> BCC	<input type="checkbox"/> Actinic Keratosis	<input type="checkbox"/> Unknown Skin Cancer
Father	<input type="checkbox"/> None	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Atypical Moles	<input type="checkbox"/> SCC	<input type="checkbox"/> BCC	<input type="checkbox"/> Actinic Keratosis	<input type="checkbox"/> Unknown Skin Cancer
Sister(s)	<input type="checkbox"/> None	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Atypical Moles	<input type="checkbox"/> SCC	<input type="checkbox"/> BCC	<input type="checkbox"/> Actinic Keratosis	<input type="checkbox"/> Unknown Skin Cancer
Brother(s)	<input type="checkbox"/> None	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Atypical Moles	<input type="checkbox"/> SCC	<input type="checkbox"/> BCC	<input type="checkbox"/> Actinic Keratosis	<input type="checkbox"/> Unknown Skin Cancer
Daughter(s)	<input type="checkbox"/> None	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Atypical Moles	<input type="checkbox"/> SCC	<input type="checkbox"/> BCC	<input type="checkbox"/> Actinic Keratosis	<input type="checkbox"/> Unknown Skin Cancer
Son(s)	<input type="checkbox"/> None	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Atypical Moles	<input type="checkbox"/> SCC	<input type="checkbox"/> BCC	<input type="checkbox"/> Actinic Keratosis	<input type="checkbox"/> Unknown Skin Cancer
Extended Family	<input type="checkbox"/> None	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Atypical Moles	<input type="checkbox"/> SCC	<input type="checkbox"/> BCC	<input type="checkbox"/> Actinic Keratosis	<input type="checkbox"/> Unknown Skin Cancer