

Patient History Questionnaire

Patient Name: _____ Date of Birth: ____ / ____ / ____

Specific Area of Concern: _____

Allergies:

Medication or Substance	Reaction or Symptom
_____	_____
_____	_____

Current Medications (including Supplements):

Name and dosage	Name and dosage	Name and dosage
_____	_____	_____
_____	_____	_____

Past Medical History:

Please check all that apply

- | | |
|--|--|
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Heart Problems: _____ | <input type="checkbox"/> Skin Cancer/Disease |
| <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> High Cholesterol | Other: _____ |

Please list any surgeries/hospitalizations with dates

Family Medical History: Please list any direct relatives with a history of *skin cancer* or *skin disease*

Social History:

Occupation: _____	Where did you grow up? _____
Alcohol Use: ___ Yes ___ No	Number of drinks per week? _____
Tobacco Use: ___ Current ___ Former ___ Never	Tanning Bed Use: ___ Current ___ Former ___ Never

Females Only:

Are you currently pregnant or trying to get pregnant? ___ Yes ___ No Are you currently nursing? ___ Yes ___ No

Date of last menstrual period: ____/____/____ Current contraception/birth control method: _____

	YES	NO		YES	NO
Skin	---	---	Gastrointestinal	---	---
Itching			Nausea/Vomiting		
Rashes			Diarrhea		
Non-healing sore(s)			Cardiovascular	---	---
Dry skin/lips			Pacemaker		
Acne			Currently taking blood thinners/Aspirin		
Mole Changes			Respiratory	---	---
New Growth			History of Asthma/Wheezing/Shortness of Breath <i>(If yes, circle appropriate answer)</i>		
Constitutional	---	---	Ear/Nose/Throat	---	---
Weight Loss			Nose Bleeds		
Fatigue			Hay Fever		
Fever			Musculoskeletal	---	---
Psych	---	---	Joint Pain		
Depression			Eyes	---	---
Neurological	---	---	Dry Eyes		
Headaches			Blurred Vision		
Vasovagal Reaction/Fainting with Blood Draws			Lymph Nodes		
			Painful/Swollen Lymph Nodes	---	---