Medical History Questionnaire

Patient Name: ______________________________________ _ Date of Birth ___________ Occupation ____________

Today's Date: _____________________ Reason for today's visit: ____

Are you allergic to any medications? YES NO If yes, list below:

____

List any products applied to skin today or recently (e.g., lotions, makeup): ____________________________________

List all medications you are currently taking (prescriptions, over-the-counter medications for pain, vitamins, and herbals):

____

____

If taking pain medication, when was your last dose: ________________________

MEDICAL HISTORY

Do you have any past or present problems with:

	YES	NO
Heart (or heart murmur)	☐	☐
High blood pressure	☐	☐
Blood disorder, excessive bleeding or easy bruising	☐	☐
History of hepatitis	☐	☐
History of HIV	☐	☐
Fatigue	☐	☐
Develop rash in the sun	☐	☐
Depression	☐	☐
Problem with wound healing or scars that you do not like	☐	☐
Joint pain or swelling	☐	☐
Shortness of breath/wheezing	☐	☐
Fingers turn white in cold	☐	☐
Do you have:		
• a pacemaker or defibrillator?	☐	☐
• an artificial valve?	☐	☐
• artificial joints?	☐	☐

Females Only

	YES	NO
Irregular periods	☐	☐
Excessive hair growth	☐	☐
Are you pregnant or considering pregnancy?	☐	☐
Are you breastfeeding?	☐	☐

Have you ever had:

	YES	NO
Skin cancer or pre-cancer	☐	☐
An abnormal mole	☐	☐
Melanoma	☐	☐
Asthma, eczema, hay fever (circle all that apply)	☐	☐
Any skin disease (e.g., psoriasis, acne, etc.)	☐	☐

Please supply details below:

____

____

List any medical problems not mentioned:

____________________ ____________________

List any Surgeries (include mth/yr):

____________________ ____________________

List other Hospitalizations (include mth/yr):

____________________ ____________________

FAMILY HISTORY

Has anyone in your family ever had:

	PARENT	SIBLING	OTHER	NONE
Skin cancer or pre-cancer	☐	☐	☐	☐
Abnormal moles	☐	☐	☐	☐
Melanoma	☐	☐	☐	☐
Any skin disease (e.g. psoriasis)	☐	☐	☐	☐
Asthma, eczema, hay fever	☐	☐	☐	☐
Severe acne	☐	☐	☐	☐

Please supply details below:

____

LIVING ARRANGEMENTS: with spouse ☐

with family ☐ roommates ☐ alone ☐

	YES	NO
Do you use tobacco?	☐	☐
Have you had a blistering sunburn?	☐	☐
Do you use sunscreen?	☐	☐

If yes, ☐ Daily ☐ Before outdoor activity

☐ Summer only ☐ Occasionally (**Usual SPF_____**)

Please choose the statement that best describes your skin:

☐ Sunburns and freckles easily, unable to tan

☐ Sunburns at first, tans slightly

☐ Sunburns occasionally, but tans readily

☐ Never sunburns, tans readily

Would you rate the amount of time you spend outdoors as:

☐ High ☐ Moderate ☐ Low