Today's Date:_____ Shore DERMATOLOGY

HEALTH INFORMATION QUESTIONNAIRE

Please fill out the following questionnaire. This will be reviewed with you in the examination room as well.

Dr. Mr. Mrs. Ms. Miss (Please Circle) Sex: Male or Female (Please Circle)

Patient's Full Name _____ Date of Birth _____

Who is the patient's primary care doctor? (Name & Address) _____

Medical History

Medications (including those not requiring a prescription-creams, Vitamins, etc.) **Check Box If You Have a List**

		10.	
		11.	
		12.	

What Pharmacy Do You Use? _____ **Specialty Pharmacy**:_____

Allergies to Medications? Yes/No If yes, please list: _____

HAS THE PATIENT EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Seasonal Allergies
Asthma
Breathing Problems/COPD

Breast Cancer
Colon Cancer
Lung Cancer
Prostate Cancer
Other Cancer: _____
Leukemia
Bleeding Disorder

High Cholesterol
High Blood Pressure
Stroke
Heart Disease
Heart Murmur
Pacemaker

Diabetes
Thyroid Disorder
Neuromuscular Disease: _____

Herpes/Cold Sores
Tuberculosis
HIV

Gastrointestinal Disease
Reflux/Ulcers
Kidney Disease
Liver Disease

Eye Disease

Seizures
Arthritis
Joint Replacement

Mental Illness
Antibiotics Prior to Procedure
Keloids/Excess Scarring
Food Allergies

Other Medical Conditions:
_____
_____

FOR FEMALE PATIENTS:

Pregnant No Yes
Periods Regular Yes No

HAS THE PATIENT EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING SKIN CONDITIONS?

Actinic Keratosis/Precancer
Basal Cell Carcinoma
Squamous Cell Carcinoma

Melanoma
Atypical Mole
Psoriasis

Eczema

DOES THE PATIENT HAVE A FAMILY HISTORY OF A FIRST DEGREE RELATIVE WITH SKIN CANCER?

Skin Cancer Yes/No If Yes, what type: Basal Cell, Squamous, Melanoma **Relative**:_____

DOES THE PATIENT HAVE A HISTORY OF ANY SURGERIES OR MAJOR HOSPITALIZATIONS (Circle All That Apply) **Surgeries:** Tonsillectomy • Adenoidectomy • Cesarean • Knee surgery • Shoulder Surgery • Heart Surgery • Cholecystectomy(Gall Bladder) • Appendectomy(Appendix) • Knee Replacement • Hip Replacement • Hernia Repair • Breast Augmentation • Tubal ligation • Hysterectomy • Oophorectomy (Ovaries) • Colonoscopy • Mastectomy • Vasectomy • Colon resection • Cataract surgery

Other:_____

Hospitalizations: Pneumonia • Child Birth • MRSA • Heart Attack •Other:_____

DO YOU HAVE A HISTORY OF TOBACCO USE? Never Former Currently

HAVE YOU RECEIVED A FLU VACCINATION RECENTLY? Yes/No Month/Year _____

HAVE YOU RECEIVED A PNEUMONIA VACCINATION? Yes/No Month/Year _____