INTEGRATED DERMATOLOGY

HEALTH QUESTIONNAIRE

PATIENT INFORMATION			**DATE:**
Last Name	First Name	M	Birthdate
Primary Care Physician			Phone
Primary reason for visit			
Referred By:			

MEDICATIONS, ALLERGIES & VACCINATIONS

PLEASE LIST ALL MEDICATIONS (PERSCRIPTION & OVER THE COUNTER)

_____ _____ _____ _____

_____ _____ _____ _____

DO YOU TAKE BLOOD THINERS? ☐No ☐Yes

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐No ☐Yes

If yes, please list: _____

_____

Are you allergic to local anesthetics? Novocaine ☐No ☐Yes Lidocaine ☐No ☐Yes
If yes, do you experience rapid heart rate with Epinephrine? ☐ No ☐ Yes

Are you taking medication that could cause immunosuppression? (Prednisone, Methotexate, Biologics/Injectable Medications, Chemotherapy) ☐No Yes

MEDICAL HISTORY

DO YOU HAVE NOW, OR HAVE YOU HAD ANY OF THE DISEASES OR CONDITIONS LISTED BELOW? PLEASE CHECK ALL THAT APPLY

- ☐ SEASONAL ALERGIES/HAY FEVER
- ☐ HIGH CHOLESTEROL
- ☐ EMPHYSEMA (COPD) ASTHMA
- ☐ STROKE
- ☐ PROSTATE
- ☐ HIGH BLOOD PRESSURE
- ☐ CHEST PAIN
- ☐ HEART SURGERY
- ☐ MITRAL VALVE PROLAPSE
- ☐ HEART ATTACK
- ☐ HEART MURMUR
- ☐ IRREGULAR HEARTBEAT
- ☐ DEPRESSION
- ☐ ANXIETY
- ☐ BLOOD CLOTS
- ☐ BIPOLAR DISEASE
- ☐ CANCER(TYPE)_____
- ☐ HIV(AIDS)
- ☐ HERPES SIMPLEX VIRUS
- ☐ DIABETES
- ☐ THYROID
- ☐ KIDNEY
- ☐ BLADDER
- ☐ STOMACH/ ULCERS
- ☐ COLON/BOWEL DISEASE
- ☐ HEPATITS OR YELLOW SKIN
- ☐ EYE DISORDER
- ☐ ARTHRITIS/JOINT DEFORMITY
- ☐ SEIZURES
- ☐ TUBERCULOSIS
- ☐ JOINT REPLACEMENT

DO YOU HAVE A PACEMAKER OR DEFIBRILLATOR? YES NO

MEDICAL HISTORY CONT.

PAST SURGERIES (Within 5 years): _____

_____

_____

Are you pregnant or planning a pregnancy ? ☐No ☐ Yes

Are you currently nursing? ☐ No ☐ Yes

Are currently on a contraceptive, and if so, what form? ☐ No ☐Yes _____

DERMATOLOGICAL HISTORY

HAVE YOU HAD SKIN CANCER? ☐No ☐ Yes

If yes which type? ☐Melanoma ☐Basal Cell Cancer ☐Squamous Cell Cancer

Has anyone in your family had skin cancer? ☐No ☐Yes If yes, who? _____

If yes, which type? ☐Melanoma ☐Basal Cell Cancer ☐Squamous Cell Cancer

Do you have a history of any specific skin problems? _____

If yes, has this been previously treated? ☐No ☐Yes If yes, with which medications/ procedures?

_____

_____

SOCIAL HISTORY

When you are exposed to the sun do you:

☐always burn
☐usually burn, tan minimally
☐sometimes mild burn,tan uniformly
☐ rarely burn, always tan well
☐ very rarely burn, tan very easily
☐ never burn, tan very easily

Do you wear sunscreen? ☐No ☐Yes What level SPF? _____

Smoking: ☐No ☐Former ☐Yes, packs/day _____

Alcohol: ☐No ☐ Yes, how much/often _____

Vaccinations received within the year ☐FLU ☐PNEUMONIA

By signing, I am acknowledging that I have disclosed all of my health information known to me at this time, and all of my other personal information is accurate. I understand that it is my obligation and responsibility to notify Integrated Dermatology of Clinton of any changes in my medical information during the course of my medical treatment.

SIGNATURE _____ Date _____