COMPLETE DERMATOLOGY

Medical Questionnaire

Name: ______________________________ Date of Birth: _______________ Today's Date: ________________

How did you find us? Internet/ Family or Friend (Name: ___________) / Physician (Name: ________________)

The reason for today's visit: _______________________________________

How long has this issue or illness been present ____

What have you tried to treat it? _________________Pharmacy Name Number___________________________

Check the following medical conditions that you currently have:

☐ None	☐ Anxiety	☐ Arthritis	☐ Asthma
☐ Atrial Fibrillation	☐ Bone Marrow Transplant	☐ BPH	☐ Breast Cancer
☐ Colon Cancer	☐ COPD	☐ Coronary Artery Disease	☐ Depression
☐ Diabetes	☐ End Stage Renal Failure	☐ GERD	☐ Hearing Loss
☐ Hepatitis	☐ Hypertension	☐ HIV/AIDS	☐ High Cholesterol
☐ Hyperthyroidism	☐ Hypothyroidism	☐ Leukemia	☐ Lung Cancer
☐ Lymphoma	☐ Prostate Cancer	☐ Radiation Treatment	☐ Seizures
☐ Stroke	Other: ____		

Please List All Past Surgeries:

Year______Surgery Performed_____________________ Year______Surgery Performed_________________

For FEMALES only: Are you breastfeeding or trying to get pregnant? _________

Have you had any of the following skin conditions? Check only those that apply to you.

☐ None	☐ Acne	☐ Actinic Kerasotes	☐ Asthma
☐ Basal Cell Carcinoma	☐ Blistering Sunburns	☐ Dry Skin	☐ Eczema
☐ Flaking Itchy Scalp	☐ Hay Fever/Allergies	☐ Melanoma	☐ Poison Ivy
☐ Precancerous Moles	☐ Psoriasis	☐ Squamous Cell Carcinoma	☐ Other

Name: ______________________________________ Today's Date: ____________________________

If you have had Basal Cell, Squamous Cell or Melanoma, please indicate location of the body below.
____

Do you wear Sunscreen? ______ If so, what SPF? ________ Do you use a tanning salon? _______

Family History
Do you have a family member with Melanoma? Yes/No If yes, which relative? _____________________

Current Medications: Please list the medication and the dosage and how many times per day you take it.

Medication Name Strength How many times per day
____
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Do you have any allergies:
Please list below ____

Allergy and type of reaction ____
Allergy and type of reaction ____
Allergy and type of reaction ____
Allergy and type of reaction ____

Other Information:

Do you smoke? ____ If yes, how many packs per day? _______ Total years smoking? __________

Do you use drugs? ____ If yes, have you used IV drugs? How long? ___________________________

Do you drink Alcohol? _____ If yes, how many per day? ___________________

Please use this space to add additional information, surgeries, or medications:

____
____

Name: ______________________________ Today's Date: _______________________

Do you have/had any of the following? Put a check mark in the box IF it applies to you and your health history.

- ☐ RASH
- ☐ PROBLEMS WITH SCARRING
- ☐ PROBLEMS WITH HEALING
- ☐ HISTORY OF MELANOMA
- ☐ ARE YOU TAKING BLOOD THINNERS
- ☐ PROBLEMS WITH BLEEDING
- ☐ PACEMAKER OR DEFIBRILLATOR
- ☐ ALLERGY TO LATEX OR ADHESIVES
- ☐ ALLERGY TO LIDOCAINE
- ☐ ACHY JOINTS
- ☐ ALLERGY TO TOPICAL ANTIBIOTIC OINTMENTS
- ☐ ARTIFICIAL HEART VALVE
- ☐ ARTIFICIAL JOINTS WITHIN LAST 2 YEARS
- ☐ SHORTNESS OF BREATH
- ☐ PREMEDICATE PRIOR TO PROCEDURES
- ☐ IMMUNO SUPPRESSION
- ☐ HAY FEVER
- ☐ CHEST PAIN
- ☐ FEVER OR CHILLS
- ☐ NIGHT SWEATS
- ☐ UNINTENTIONAL WEIGHT LOSS
- ☐ THYROID PROBLEMS
- ☐ SORE THROAT
- ☐ BLURRY VISION
- ☐ ABDOMINAL PAIN
- ☐ MUSCLE WEAKNESS
- ☐ NECK STIFFNESS
- ☐ HEADACHES
- ☐ SEIZURES
- ☐ COUGH
- ☐ DEPRESSION

X____ ____________________

Please type your First and Last Name Date

Acceptance Checkbox

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

Please click the button below to 'Submit' your completed New Patient Medical Questionnaire Form.

Submit Form