

Patient Label Here

Dermatology Health History Questionnaire

NAME: _____ **Date of Birth:** _____
Last First Middle (MI)

Referring Physician: _____ **Primary Care Physician** _____

Reason you are being seen today/Date symptoms began: _____

Previous treatment(s) for this problem and by which Doctor: _____

General Health: Do you have current or past problems with?

	No	Yes	If "Yes" please explain
HIV	___	___	_____
Eyes	___	___	_____
Ears/Nose/Throat/Mouth	___	___	_____
Heart	___	___	_____
Lungs	___	___	_____
Stomach/Bowel	___	___	_____
Kidneys	___	___	_____
Arthritis	___	___	_____
Skin	___	___	_____
Headaches/Seizures	___	___	_____
Psychological Disorder	___	___	_____
Thyroid/Diabetes	___	___	_____
Blood/Bleeding Disorder	___	___	_____
Allergic/Immunological	___	___	_____

Prescribed Medications: _____

Non-Prescription Meds: _____

Drug Allergies: _____

Family History:

Mother: Living: _____ Deceased: _____ Age: _____ **Father:** Living: _____ Deceased: _____ Age: _____

Which of your blood relatives had or have any of the following diseases?

<u>Disease</u>	<u>Mother</u>	<u>Father</u>	<u>Blood Relative</u>	<u>Disease</u>	<u>Mother</u>	<u>Father</u>	<u>Blood Relative</u>
Allergies	___	___	___	Heart Disease	___	___	___
Arthritis	___	___	___	High Blood Pressure	___	___	___
Asthma	___	___	___	Lung Disease	___	___	___
Cancer	___	___	___	Malignant Melanoma	___	___	___
Diabetes	___	___	___	Psoriasis	___	___	___
Eczema	___	___	___	Skin Cancer	___	___	___
Hay Fever	___	___	___	Tuberculosis	___	___	___

Social History:

Do you live alone? ___yes ___no Do you smoke? ___yes ___no
 Do you drink alcohol ___yes ___no Do you use recreational drugs? ___yes ___no