DERMWELLESLEY

Medical History Questionnaire

Patient Name:	**DOB:**	**Date:**

We hope you will fill this out to the best of your ability, as it will help us provide you with safe and high-quality care. Although some of these questions may seem unrelated to your skin, we ask them because often they will help us with your diagnosis, treatment and follow up plan. Skin problems can sometimes be associated with other organ systems and conditions, which is why your entire medical, surgical, and social history is important to us. **Please complete this form to the best of your ability.**

What is the primary reason for your visit today? _____

How did you hear about our office, or who were you referred by? _____

Preferred Pharmacy: _____ Pharmacy street and city: _____

Review of Systems, check all the apply**:**

Eyes:
- ☐ Double/blurred vision
- ☐ Itchy/Dry eyes
- ☐ Eye drainage

Gastrointestinal
- ☐ Abdominal pain
- ☐ Nausea/vomiting
- ☐ Frequent heartburn
- ☐ Frequent Diarrhea
- ☐ Frequent constipation

Hematology:
- ☐ Bleeding problems
- ☐ Bruising easily

Psychologic:
- ☐ Anxiety
- ☐ Mood Swings
- ☐ Depression

Neurologic:
- ☐ Severe headaches
- ☐ Numbness/tingling
- ☐ Dizziness or fainting
- ☐ Memory loss
- ☐ Difficulty walking

Musculoskeletal:
- ☐ Joint pain
- ☐ Cramps or spasm

Endocrine:
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Increased thirst

Ear/Nose/Throat
- ☐ Sinus problem
- ☐ Hearing loss
- ☐ Difficulty swallowing
- ☐ Sore throat

Constitutional:
- ☐ Fatigue
- ☐ Weakness
- ☐ Extreme weight fluctuation

Respiratory:
- ☐ Shortness of breath
- ☐ Frequent cough
- ☐ Congestion

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations/fluttering
- ☐ Varicose veins
- ☐ Limb swelling

Urology:
- ☐ Difficult or painful urination
- ☐ Frequent urination
- ☐ Blood in urine

General Medical History, check all that apply:

- ☐ **Joint replacement**
- ☐ Heart disease
- ☐ IV drug use
- ☐ Artificial joints
- ☐ Diabetes
- ☐ Seizure disorder
- ☐ Psoriasis

- ☐ **Artificial heart valve**
- ☐ Heart murmurs
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Organ transplant
- ☐ Abnormal scars/keloids
- ☐ Rheumatoid arthritis

- ☐ **Pacemaker/defibrillator**
- ☐ Arrythmia
- ☐ Asthma
- ☐ Hepatitis (B or C)
- ☐ AIDS or HIV
- ☐ Abnormal moles
- ☐ Lupus

- ☐ Bleeding disorder
- ☐ Environmental allergies
- ☐ Liver disease
- ☐ Emphysema or COPD
- ☐ **Herpes (genital or mouth)**
- ☐ **Auto immune disease**

Use this space for explanations and other medical conditions:

_____

_____

_____

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List all medications including prescription, nonprescription, and topical medications; or attach a separate list:

_____

_____

List all allergies, including medications, food, latex, or contact allergens:

_____

_____

Personal history of skin cancer, precancerous lesions, or atypical moles:

☐ None ☐ Basal cell ☐ Squamous cell cancer ☐ Melanoma ☐ Actinic Keratosis ☐ Atypical Moles ☐ Other

Use this space to further explain location and treatment:

_____

_____

Family History:

☐ Adopted and/or family history unknown

Is a blood relative affected by any of the following?

☐ Skin Cancer:

☐ Basal Cell ☐ Squamous Cell ☐ Melanoma

Which relative? _____

☐ Autoimmune disorders:

☐ Rheumatoid Arthritis ☐ Lupus

☐ Psoriasis ☐ Thyroid Disease

Which relative: _____

Social History:

Do you smoke? ☐ Y ☐ N

Are you a former smoker? ☐ Y ☐ N

Do you use alcohol? ☐ Y ☐ N

Personal History:

History of severe sunburns? Y ☐ N ☐

History of tanning booth use? Y ☐ N ☐

Do you wear sunscreen? Y ☐ N ☐

Do you live alone: Y ☐ N ☐

Are you working: Y ☐ N ☐

Occupation: _____

Female patients:

Are you trying to get pregnant? Y ☐ N ☐

Are you pregnant now? Y ☐ N ☐

If yes, what is your due date? _____

Are you breastfeeding now? Y ☐ N ☐

Are you post-menopausal? Y ☐ N ☐

Who is filling out this form? ☐ Patient ☐ Other, please specify relationship to patient: _____