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:

**History of Cancer,** please specify which type(s): ______________________________

- ☐ **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: ______________________________