

# Naperbrook Dermatology

## Medical History Questionnaire (Please fill in all circles completely)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Who were you referred by? Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Are you allergic to any medications? (If yes, list meds and reactions below) No  Yes

If yes, describe: \_\_\_\_\_

Have you ever had a reaction to Novocaine, Lidocaine, bandages, latex, or topical antibiotics (i.e. Neosporin)

If yes, describe: \_\_\_\_\_

Please list below current medications you are taking (including prescriptions, over the counter meds, vitamins, and herbal supplements):

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

5. \_\_\_\_\_ 6. \_\_\_\_\_ 7. \_\_\_\_\_ 8. \_\_\_\_\_

Do you have any significant medical problems? No  Yes – See next question

### Have you ever had a history of?

- |                                       |                           |                                 |                           |
|---------------------------------------|---------------------------|---------------------------------|---------------------------|
| Mitral Valve Prolapse                 | Yes <input type="radio"/> | Diabetes                        | Yes <input type="radio"/> |
| Pacemaker/Defibrillator               | Yes <input type="radio"/> | Thyroid Disease                 | Yes <input type="radio"/> |
| HIV/AIDS                              | Yes <input type="radio"/> | Kidney Disease/Failure          | Yes <input type="radio"/> |
| Joint Replacement (Year: _____)       | Yes <input type="radio"/> | Arthritis                       | Yes <input type="radio"/> |
| Hepatitis A, B, C                     | Yes <input type="radio"/> | Liver Disease                   | Yes <input type="radio"/> |
| Artificial Heart Valves (Year: _____) | Yes <input type="radio"/> | Depression or Anxiety           | Yes <input type="radio"/> |
| Histroy of Bacterial Endocarditis     | Yes <input type="radio"/> | Lupus                           | Yes <input type="radio"/> |
| Emphysema/COPD                        | Yes <input type="radio"/> | Convulsions, Seizures, Epilepsy | Yes <input type="radio"/> |
| Irregular Heartbeat                   | Yes <input type="radio"/> | Cancer (Type: _____)            | Yes <input type="radio"/> |
| Asthma                                | Yes <input type="radio"/> | Seasonal Allergies/Hay fever    | Yes <input type="radio"/> |
| Fainting                              | Yes <input type="radio"/> | History of Blood Transfusion    | Yes <input type="radio"/> |
| High Blood Pressure                   | Yes <input type="radio"/> | Heart Failure                   | Yes <input type="radio"/> |
| Heart Attack                          | Yes <input type="radio"/> |                                 |                           |

List any other diseases or conditions: \_\_\_\_\_

### Dermatologic History

- Skin Cancer (Type unknown) Yes
- Melanoma Yes
- Atypical/Dysplastic Moles Yes
- Squamous Cell Carcinoma Yes
- Basal Cell Carcinoma Yes
- Actinic Keratosis Yes
- History of Keloids/Thick scarring Yes
- Psoriasis Yes
- Atopic Dermatitis Yes
- Hives Yes

### Family Dermatologic History

- None Yes
- Melanoma Yes
- Atypical/Dysplastic Moles Yes
- Squamous Cell Cancer Yes
- Basal Cell Cancer Yes
- Actinic Keratosis Yes
- Unknown Skin Cancer Yes
- Psoriasis Yes
- Atopic Dermatitis Yes

### Social history

- Occupation: \_\_\_\_\_ Yes
- Have you ever had a sunburn? Yes
- Do you or have you ever used a tanning Bed? Yes
- Do you use sunscreen? Yes
- Do you now or have you ever used alcohol? Yes
- Do you now or have you ever used tobacco? Yes
- Do you now or have you ever used any illegal drugs? Yes

### Review of Symptoms

- |                  |                           |                           |                           |
|------------------|---------------------------|---------------------------|---------------------------|
| Fevers/Chills    | Yes <input type="radio"/> | Irregular Periods         | Yes <input type="radio"/> |
| Weight Loss      | Yes <input type="radio"/> | Oral/Patch contraceptives | Yes <input type="radio"/> |
| Loss of Appetite | Yes <input type="radio"/> | Pregnant                  | Yes <input type="radio"/> |
| Night Sweats     | Yes <input type="radio"/> | Breastfeeding             | Yes <input type="radio"/> |
| Joint Aches      | Yes <input type="radio"/> | PCOS                      | Yes <input type="radio"/> |
| Photosensitivity | Yes <input type="radio"/> | Easy Bleeding/Bruising    | Yes <input type="radio"/> |
| Cough            | Yes <input type="radio"/> | Shortness of Breath       | Yes <input type="radio"/> |
| Abdominal Pain   | Yes <input type="radio"/> | Nausea/Vomiting           | Yes <input type="radio"/> |
| Diarrhea         | Yes <input type="radio"/> | Chest Pain                | Yes <input type="radio"/> |
| Vision Problems  | Yes <input type="radio"/> | Headaches/Migraines       | Yes <input type="radio"/> |

If yes, describe: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_