Northwest Dermatology

Medical History Questionnaire

Name: _____ Date: _____

Who were you referred by? Name: _____

Who is your primary doctor? Name: _____ Phone #: _____

Are you allergic to any medications? **No O Yes O**
If yes, list meds and reactions:

_____

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

Please list 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 take antibiotics when you go to the dentist? No O Yes O
Do you have any significant medical problems? No O Yes O – See next question

Have you ever had a history of?

Mitral Valve Prolapse	Yes O	Diabetes	Yes O
Pacemaker/Defibrillator	Yes O	Thyroid Disease	Yes O
HIV/AIDS	Yes O	Kidney Disease/Failure	Yes O
Joint Replacement (Year: _____ and Site:_____)	Yes O	Cancer (Type:_____)	Yes O
Hepatitis A, B, C	Yes O	Liver Disease	Yes O
Artificial Heart Valves (Year: _____)	Yes O	Depression or Anxiety	Yes O
History of Bacterial Endocarditis	Yes O	Lupus	Yes O
Emphysema/COPD	Yes O	Seizures/Epilepsy	Yes O
Irregular Heartbeat/Arrhythmia	Yes O	Arthritis	Yes O
Asthma	Yes O	Seasonal Allergies/Hay fever	Yes O
Heart Failure	Yes O	Blood Transfusion	Yes O
High Blood Pressure	Yes O	High Cholesterol or Triglycerides	Yes O
Heart Attack	Yes O	Blood Clots	Yes O

List any other diseases or conditions:_____

Dermatologic History

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

Family Dermatologic History

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

Social history

Occupation: _____	
Have you ever had a sunburn?	Yes O
Do you or have you ever used a tanning bed?	Yes O
Do you use sunscreen?	Yes O
Do you use alcohol? How much? _____	Yes O
Do you use tobacco? How much? _____	Yes O
Do you now or have you ever used illegal drugs?	Yes O

Review of Systems

Fevers/Chills	Yes O	Irregular Periods	Yes O
Weight Loss	Yes O	Contraceptives	Yes O
Loss of Appetite	Yes O	Pregnant	Yes O
Night Sweats	Yes O	Breastfeeding	Yes O
Joint Aches	Yes O	Easy Bleeding	Yes O
Photosensitivity	Yes O	Easy Bruising	Yes O
Cough	Yes O	Shortness of Breath	Yes O
Abdominal Pain	Yes O	Nausea/Vomiting	Yes O
Diarrhea	Yes O	Chest Pain	Yes O
Vision Problems	Yes O	Headaches/Migraines	Yes O

If yes, describe:_____

Patient's Signature:_____ Physician's Signature:_____