

**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**  **Yes**

**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**  **Yes**

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

**Have you ever had a history of?**

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

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

**Dermatologic History**

Skin Cancer (Type unknown)	Yes <input type="radio"/>
Melanoma	Yes <input type="radio"/>
Atypical/Dysplastic Moles	Yes <input type="radio"/>
Squamous Cell Carcinoma	Yes <input type="radio"/>
Basal Cell Carcinoma	Yes <input type="radio"/>
Actinic Keratosis/Sun Damage	Yes <input type="radio"/>
History of Keloids/Thick scarring	Yes <input type="radio"/>
Psoriasis	Yes <input type="radio"/>
Atopic Dermatitis	Yes <input type="radio"/>

**Family Dermatologic History**

None	Yes <input type="radio"/>
Melanoma	Yes <input type="radio"/>
Atypical/Dysplastic Moles	Yes <input type="radio"/>
Squamous Cell Cancer	Yes <input type="radio"/>
Basal Cell Cancer	Yes <input type="radio"/>
Actinic Keratosis	Yes <input type="radio"/>
Unknown Skin Cancer	Yes <input type="radio"/>
Psoriasis	Yes <input type="radio"/>
Atopic Dermatitis	Yes <input type="radio"/>

**Social history**

Occupation: _____	
Have you ever had a sunburn?	Yes <input type="radio"/>
Do you or have you ever used a tanning bed?	Yes <input type="radio"/>
Do you use sunscreen?	Yes <input type="radio"/>
Do you use alcohol? How much? _____	Yes <input type="radio"/>
Do you use tobacco? How much? _____	Yes <input type="radio"/>
Do you now or have you ever used illegal drugs?	Yes <input type="radio"/>

**Review of Systems**

Fevers/Chills	Yes <input type="radio"/>	Irregular Periods	Yes <input type="radio"/>
Weight Loss	Yes <input type="radio"/>	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"/>	Easy Bleeding	Yes <input type="radio"/>
Photosensitivity	Yes <input type="radio"/>	Easy 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: \_\_\_\_\_