

DERMATOLOGY QUESTIONNAIRE

Patient Name: _____

Today's Date: _____

Reason for Visit: (Chief Complaint)

Medication Allergies: _____

Current Medications: _____

Date of Onset: _____

Current or past problems with: (Review of Systems)

Please include all conditions for which you have been under a physician's care and/or are on medications.

	Yes	No	(If yes, explain)
Do you have Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	_____
General Health	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears/Nose/Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach/bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis/muscles/joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin (rashes, cancer, melanoma)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches/seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid/diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood/bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/immunologic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have HIV or Aids?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Females: Are you pregnant? Yes No Are you planning to become pregnant in the next 6 months? Yes No

Family History: (Past family & social history)

Check following medical conditions that have occurred in your family:

Disease	Mother	Father	Blood Relative
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malignant Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History:

	Yes	No	frequency?
Do you use a tanning bed?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you work/tan outdoors?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you live alone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Occupation: _____

Hobbies/leisure activities: _____

Signed: _____ Relationship to Patient: _____ Date: _____

(Patient/guarantor)