HEALTH QUESTIONNAIRE

Patient Name ______________________________ Age ________ Date _____ /_____ /_____

Reason for Visit ____

Current or Past Medical Conditions

☐ Allergic Rhinitis (Hay Fever)
Anemia
Arthritis
Asthma
Atrial Fibrillation
Bipolar Disorder
Blood Clotting Disorder
Breast Cancer
Colon Cancer
Cataract
Colitis
Coronary Heart Disease
Congestive Heart Failure
Depression
Diabetes
Elevated Cholesterol
Gastritis
Glaucoma
Genital Herpes
Hepatitis B
Hepatitis C
Hearing Loss
Heart Attack
Heart Valve Disease
Heart Valve Replacement
Hypertension
Hyperthyroidism
Hypothyroidism
HIV or AIDS
Irritable Bowel
Kidney Disease
Liver Disease
Lupus
Migraines
Mitral Valve Prolapse
Multiple Sclerosis
Osteopenia
Osteoporosis
Peptic Ulcer Disease
Pace Maker or Defibrillator
Prostate Cancer
Pulmonary Embolism
Prosthetic Joint or Implant
Seizure
Stroke
Tuberculosis
Varicose Veins
Weight Loss (Intentional)
Weight Loss (Unexplained)

☐ Other ____

Dermatology History

Abnormal Moles
Acne
Actinic Keratosis
Eczema
Herpes or Cold Sores
Hyperpigmentation
Increased Hair Growth
Hair Loss
Melanoma
Nail Problem
Psoriasis
Shingles
Thick Scars or Keloids
Skin Cancer
Other____________________

Family History

Arthritis	☐Mother	☐ Father	☐Blood Relative
Asthma	☐Mother	☐ Father	☐Blood Relative
Depression	☐Mother	☐ Father	☐Blood Relative
Diabetes	☐Mother	☐ Father	☐Blood Relative
Breast Cancer	☐Mother	☐ Father	☐Blood Relative
Heart Disease	☐Mother	☐ Father	☐Blood Relative
Thyroid Disease	☐Mother	☐ Father	☐Blood Relative
Other	☐Mother	☐ Father	☐Blood Relative

Family History of Skin Disease

Abnormal Moles	☐Mother	☐ Father	☐Blood Relative
Acne	☐Mother	☐ Father	☐Blood Relative
Eczema or Dermatitis	☐Mother	☐ Father	☐Blood Relative
Melanoma	☐Mother	☐ Father	☐Blood Relative
Skin Cancer	☐Mother	☐ Father	☐Blood Relative
Psoriasis	☐Mother	☐ Father	☐Blood Relative
Thick Scars or Keloids	☐Mother	☐ Father	☐Blood Relative

Immunizations

☐ Pneumococcal Vaccine ☐ Tetanus Vaccine ☐ Influenza Vaccine ☐ Shingles Vaccine

Social History

Sunscreen Usage Daily Occasionally Never

Alcohol Use Yes Social Daily Beer Wine Liquor
Never Ex- Drinker

Illicit Drug Use Yes Recreational Drug Use Ex-Drug Use Never

Marital Status Married Divorced Separated Single Widowed

Smoking Status Current Smoker Light Moderate Heavy Occasional
Former Smoker Never Smoked Cigar Smoker

Surgeries and/or Hospitalizations

Hospitalizations______________________________

Cosmetic Surgeries ______________________________
Cosmetic Procedures
Filler Injections ______________________________
Botox Dysport Xeomin Laser Peels
Other ______________________________

Other Surgeries ______________________________

Current Medications ______________________________

Vitamins and Herbal Supplements ______________________________

Allergies Medications ______________________________

Latex Anesthetics ______________________________

Females Only

Dysmenorrhea
Endometriosis
Infertility
Irregular Periods
Polycystic Ovarian Disease
Menopausal Symptoms
Postmenopausal
Breastfeeding
Not Pregnant
Pregnant
Planning to Become Pregnant No Yes When? ______________
Date of Last Menstrual Period ____ /____ /____ N/A

Patient Signature ______________________________ **Date** _____ /______/______