DERMATOLOGY & LASER CENTER

Medical Center Clinic
HEALTHCARE CENTERED AROUND YOU

NEW PATIENT QUESTIONNAIRE

PERSONAL INFORMATION

Name ____________________ Age ________ DOB ____________

SS# ________________ Military Sponsor's SS# (If Applicable) ____________________

Primary/Referring Physician ________________/________________

Primary/Secondary Insurance ________________/________________

PAST MEDICAL HISTORY – Please place an **[X]** in each box below if you **have had (or currently have)** any of the following medical conditions? **Please BRIEFLY explain all [X's] below (use back of sheet if necessary).**

[ ] Depression/Psychiatric Disorders
[ ] Heart Disease/Heart Attack
[ ] Liver or Kidney Disease (Dialysis?)
[ ] Muscle Disease
[ ] Diabetes
[ ] Bleeding Disorders
[ ] Neurological Disease/Strokes/Seizures
[ ] Artificial heart Valves/Pacemaker
[ ] Gastrointestinal Disease (i.e. Crohn's, IBS)
[ ] Artificial Joints/Rheumatoid Arthritis
[ ] Cancer (i.e. Breast, Colon, Lung, Prostate)
[ ] HIV/AIDS/Hepatitis/Tuberculosis
[ ] Thyroid Disease/Endocrine Disorders
[ ] Asthma/Emphysema/Lung Disease
[ ] Genital or Urinary System Disease
[ ] Autoimmune Disease (i.e. Lupus)
[ ] High Blood Pressure
[ ] Other (i.e. major surgeries, etc.)

Please explain all [X's]____

____

____

[ ] **Skin Disease**

Have **you** ever had **skin cancer**? [ ] Yes [ ] No **If yes, please mark type(s) below**:
[ ] Melanoma [ ] Basal Cell Carcinoma [ ] Squamous Cell Carcinoma [ ] Actinic Keratoses [ ] Other

Do you have a history of any **specific skin diseases**? [ ] Yes [ ] No **Explain**: ____________

Has anyone in your **family** had **skin cancer**? [ ] Yes [ ] No **Explain**: ____________

Is there a **family** history of **skin disorders**? [ ] Yes [ ] No **Explain**: ____________
i.e. Psoriasis, Eczema, Lupus, Vitiligo, etc. ____________

Do you develop **keloids** (large scars) after surgery? [ ] Yes [ ] No **Explain**: ____________

Do you develop **skin reactions** to: [ ] Medications [ ] Foods [ ] Environment [ ] Bandages [ ] Neosporin [ ] Other

ALLERGIES – are you allergic to any **medications**? If yes, please explain: ____________

____

Have you ever had dental anesthesia (Novacaine)?[ ] Yes [ ] No Any bad reaction? [ ] Yes [ ] No

MEDICATIONS – Please list **all current medications** including prescription, over-the-counter, vitamins, and herbal supplements:

________________ ________________ ________________

________________ ________________ ________________

________________ ________________ ________________

SOCIAL HISTORY

Current **Occupation**:____

History of **Outdoor Occupations** (i.e. Farmer, Construction, Lifeguard, Fisherman, etc.) ____________

[ ] Yes [ ] No Do you have any **pets**, farm animals, or wild animals in or around the home? Explain: ____________
[ ] Yes [ ] No **Tobacco use**? How much daily? ____________
[ ] Yes [ ] No **Alcohol use**? How much daily? ____________
[ ] Yes [ ] No **WOMEN** – Are you currently **pregnant** (or breastfeeding) or planning on becoming pregnant in the near future?

Patient Phone Number(s): Home ____________ **Work** ____________ **Cell** ____________

Patient Signature ________________________ **Date** ____________

Reviewed by Dermatology Provider ________________ **Date** ____________

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