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