

SOUTH SHORE DERMATOLOGY PHYSICIANS, P.C.

Medical History Questionnaire

Date: _____

Name: _____ Primary Care Physician: _____

First

Last

First

Last

Reason for Visit: _____

Medical Problems: _____

Medications: _____ Medication Allergies (Includes Latex Allergy): _____

Medications Applied to Skin: _____

PERSONAL AND FAMILY HEALTH HISTORY (PLEASE CHECK ALL THAT APPLY)

	Self	Family	Please Explain
Skin Cancer (Basal Cell, Squamous Cell, Melanoma)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abnormal Moles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Severe Acne	<input type="checkbox"/>	<input type="checkbox"/>	_____
Keloids (Raised Scars)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear, Nose, Throat Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory (breathing) Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach or Intestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric Conditions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Menstrual Irregularities	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary/Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you use tobacco? Yes No **Do you use alcohol?** Yes No # of drinks per week _____

DEVICES AND IMPLANTS	Yes	No
Pacemaker and/or defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>

FEMALES ONLY	Yes	No
Are you pregnant or considering pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>

Please choose the statement that best describes your skin:

- Sunburns and freckles easily, unable to tan
- Sunburns at first, tans slightly
- Sunburns occasionally but tans readily
- Never sunburns, tans readily

Would you rate the amount of time you spend outdoors as:

- High Moderate Low

Do you use sunscreen? Yes No

If Yes, Daily Before outdoor activity
 Summer only Occasionally
 Usual SPF _____

Have you ever had blistering sunburns? Yes No

 Physician's Signature Date