



Date: _____

HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.I.): _____

DOB: _____

M F

Marital status: Single Partnered Married Separated Divorced Widowed

Referring doctor: _____ Date of last physical exam: _____

Occupation:

Please describe your work if you believe that your rash may be related to your occupation and/or hobbies:

Do you have any drug allergies: Yes No If yes, please list:

WOMEN ONLY

Are you pregnant?

If yes, when are you due:

Are you breast feeding?

Date of last menstruation: Yes No

Yes No

WHAT IS YOUR SKIN PROBLEM?

Moles, rash, warts, growths, acne, etc.:

When did you first notice this skin problem?

Where did it start?

Has a doctor given you anything for the condition?

If yes, please name everything you have used:

Have you put any over the counter salve, lotion, etc. on the skin yourself?

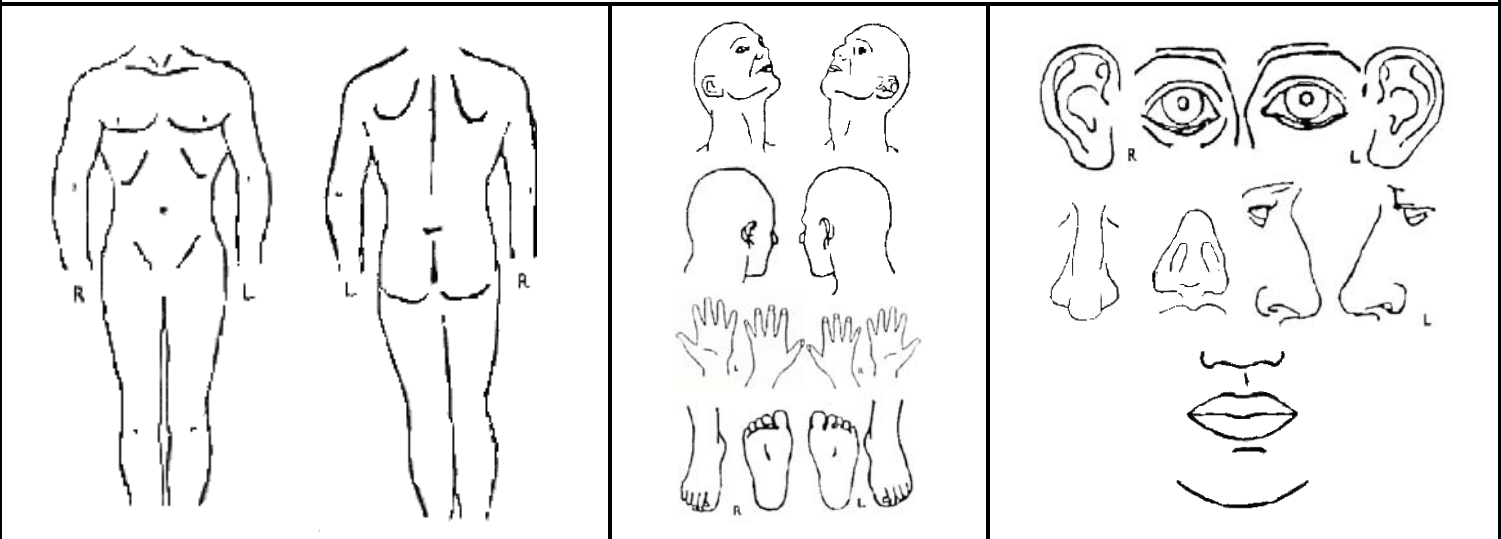
Have you ever had the same skin problem before? Yes No If yes, what was it called?

Does anyone in your family have skin cancer or skin problems? Basal Cell Carcinoma Squamous Cell Carcinoma Malignant Melanoma

Other, Please list:

Does anything touching your skin cause a rash or allergy, (jewelry, soap, etc.)?

Please mark on the figure where your present skin problem or rash is by marking x's or shading.



PERSONAL HEALTH HISTORY

How is your general health? Excellent Good Fair Poor

Do you have any of the following diseases: Please check all that apply

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Lupus	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Artificial heart valve	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Liver
<input type="checkbox"/> Prolapsed valve	<input type="checkbox"/> Chronic fatigue syndrome	<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Alzheimer's
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Artificial joints	<input type="checkbox"/> Stomach ulcer	<input type="checkbox"/> Malignant Melanoma
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Seizures	<input type="checkbox"/> G.E.R.D.	<input type="checkbox"/> Basal Cell Carcinoma
<input type="checkbox"/> History of by-pass or stent	<input type="checkbox"/> Migraine	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Squamous Cell Carcinoma
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Fainting	<input type="checkbox"/> Irritable Bowel Syndrome	
<input type="checkbox"/> Stroke	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Cancer. What kind?	

Other? Please name: _____

OVER



SURGERIES OR HOSPITALIZATIONS

Year	Reason	Year	Reason

MEDICATION

Do you take a blood thinner or aspirin daily? Yes No If yes, name of medication:

Do you take medications (antibiotics) before dental work? Yes No If yes, name of antibiotic:

List Your Prescribed Drugs:	List Your Over-The-Counter Drugs:	List Your Vitamins And Herbs:

HEALTH HABITS

Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day:			
Alcohol	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	How many drinks per week?			
Tobacco	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Cigarettes – pks./day:	<input type="checkbox"/> Chew - #/day:	<input type="checkbox"/> Pipe - #/day:	<input type="checkbox"/> Cigars - #/day:
	<input type="checkbox"/> # of years:	<input type="checkbox"/> Or year quit:		
Drugs	Do you currently use recreational or street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Have you ever injected yourself with street drugs using a needle? <input type="checkbox"/> Yes <input type="checkbox"/> No			

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother				<input type="checkbox"/> M	
Sibling	<input type="checkbox"/> M		<input type="checkbox"/> F		
	<input type="checkbox"/> F		<input type="checkbox"/> M		
	<input type="checkbox"/> M		<input type="checkbox"/> F		
	<input type="checkbox"/> F		<input type="checkbox"/> M		
	<input type="checkbox"/> M		<input type="checkbox"/> F		
	<input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> F		Grandmother <i>Paternal</i>		
<input type="checkbox"/> M		Grandfather <i>Paternal</i>			
<input type="checkbox"/> F					

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.



Patient #: _____

Date: _____

Drug Allergies: _____

Patient Information

(First, Middle, Last Name) _____
(Date of Birth)

(Address) _____
(City, State, Zip Code)

(Email Address) _____
(Social Security Number)

(Home Telephone Number) _____
(Work Telephone Number) _____
(Cell Telephone Number)

Marital Status: Single Married Divorced Widowed
 Sex: Male Female
 Employment Status: Employed Part-time Student Full-time Student Other

Patient Employment	Primary Insurance Information
_____ <i>(Employer)</i>	_____ <i>(Name of Insurance Company)</i>
_____ <i>(Address)</i>	_____ <i>(Subscriber's Name)</i>
_____ <i>(City)</i> _____ <i>(State, Zip Code)</i>	_____ <i>(Social Security Number)</i> _____ <i>(Date of Birth)</i>
_____ <i>(Phone)</i>	_____ <i>(Subscriber's Employment)</i>
	_____ <i>(Relationship to Patient)</i>

Emergency Contact	Secondary Insurance Information
_____ <i>(Name)</i>	_____ <i>(Name of Insurance Company)</i>
_____ <i>(Address)</i>	_____ <i>(Subscriber's Name)</i>
_____ <i>(City)</i> _____ <i>(State, Zip Code)</i>	_____ <i>(Social Security Number)</i> _____ <i>(Date of Birth)</i>
_____ <i>(Phone)</i>	_____ <i>(Subscriber's Employment)</i>
_____ <i>(Relationship to Patient)</i>	_____ <i>(Relationship to Patient)</i>

How did you hear about our office?

<input type="checkbox"/> By a Doctor <input type="checkbox"/> By a Patient <input type="checkbox"/> Other	<p>Please print the name, address and phone of your source below</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Is your illness or injury related to any of the following?

<input type="checkbox"/> Employment <input type="checkbox"/> Emergency <input type="checkbox"/> Accident <input type="checkbox"/> Auto Insurance	<p>Please print the name and address of your source below</p> <p>_____</p> <p>_____</p> <p>_____</p>
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