



DERMWELLESLEY

Medical History Questionnaire

Patient Name:	DOB:	Date:
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We hope you will fill this out to the best of your ability, as it will help us provide you with safe and high-quality care. Although some of these questions may seem unrelated to your skin, we ask them because often they will help us with your diagnosis, treatment and follow up plan. Skin problems can sometimes be associated with other organ systems and conditions, which is why your entire medical, surgical, and social history is important to us. **Please complete this form to the best of your ability.**

What is the primary reason for your visit today? _____

How did you hear about our office, or who were you referred by? _____

Preferred Pharmacy: _____ Pharmacy street and city: _____

Review of Systems, check all the apply:

- | | | | |
|---|--|---|--|
| Eyes:
<input type="checkbox"/> Double/blurred vision
<input type="checkbox"/> Itchy/Dry eyes
<input type="checkbox"/> Eye drainage
Gastrointestinal
<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Nausea/vomiting
<input type="checkbox"/> Frequent heartburn
<input type="checkbox"/> Frequent Diarrhea
<input type="checkbox"/> Frequent constipation
Hematology:
<input type="checkbox"/> Bleeding problems
<input type="checkbox"/> Bruising easily | Psychologic:
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Mood Swings
<input type="checkbox"/> Depression
Neurologic:
<input type="checkbox"/> Severe headaches
<input type="checkbox"/> Numbness/tingling
<input type="checkbox"/> Dizziness or fainting
<input type="checkbox"/> Memory loss
<input type="checkbox"/> Difficulty walking
Musculoskeletal:
<input type="checkbox"/> Joint pain
<input type="checkbox"/> Cramps or spasm | Endocrine:
<input type="checkbox"/> Cold intolerance
<input type="checkbox"/> Heat intolerance
<input type="checkbox"/> Increased thirst
Ear/Nose/Throat
<input type="checkbox"/> Sinus problem
<input type="checkbox"/> Hearing loss
<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Sore throat
Constitutional:
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Weakness
<input type="checkbox"/> Extreme weight fluctuation | Respiratory:
<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Frequent cough
<input type="checkbox"/> Congestion
Cardiovascular
<input type="checkbox"/> Chest pain
<input type="checkbox"/> Palpitations/fluttering
<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Limb swelling
Urology:
<input type="checkbox"/> Difficult or painful urination
<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Blood in urine |
|---|--|---|--|

General Medical History, check all that apply:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Joint replacement
<input type="checkbox"/> Heart disease
<input type="checkbox"/> IV drug use
<input type="checkbox"/> Artificial joints
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Psoriasis | <input type="checkbox"/> Artificial heart valve
<input type="checkbox"/> Heart murmurs
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Organ transplant
<input type="checkbox"/> Abnormal scars/keloids
<input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Pacemaker/defibrillator
<input type="checkbox"/> Arrhythmia
<input type="checkbox"/> Asthma
<input type="checkbox"/> Hepatitis (B or C)
<input type="checkbox"/> AIDS or HIV
<input type="checkbox"/> Abnormal moles
<input type="checkbox"/> Lupus | <input type="checkbox"/> Bleeding disorder
<input type="checkbox"/> Environmental allergies
<input type="checkbox"/> Liver disease
<input type="checkbox"/> Emphysema or COPD
<input type="checkbox"/> Herpes (genital or mouth)
<input type="checkbox"/> Auto immune disease |
|---|--|---|--|

Use this space for explanations and other medical conditions:



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List all medications including prescription, nonprescription, and topical medications; or attach a separate list:

List all allergies, including medications, food, latex, or contact allergens:

Personal history of skin cancer, precancerous lesions, or atypical moles:

- None Basal cell Squamous cell cancer Melanoma Actinic Keratosis Atypical Moles Other

Use this space to further explain location and treatment:

Family History:

- Adopted and/or family history unknown
Is a blood relative affected by any of the following?

- Skin Cancer: Basal Cell Squamous Cell Melanoma

Which relative? _____

- Autoimmune disorders: Rheumatoid Arthritis Lupus

Psoriasis Thyroid Disease
Which relative: _____

Social History:

- Do you smoke? Y N
Are you a former smoker? Y N
Do you use alcohol? Y N

Personal History:

- History of severe sunburns? Y N
History of tanning booth use? Y N
Do you wear sunscreen? Y N
Do you live alone: Y N
Are you working: Y N
Occupation: _____

Female patients:

- Are you trying to get pregnant? Y N
Are you breastfeeding now? Y N
Are you pregnant now? Y N
Are you post-menopausal? Y N
If yes, what is your due date? _____

Who is filling out this form? Patient Other, please specify relationship to patient: _____