

* Use Pen Only

Delaware Valley Dermatology Group, LLC

HEALTH QUESTIONNAIRE

Date of Visit: _____

Patient name: _____ D.O.B.: _____ Age: _____

Primary reason for visit: _____

Are you allergic to any medications? _____ Yes No If yes, please list: _____

Prescription Carrier: _____

ID #: _____ Phone #: _____

List all medications you are now taking or have taken in the last two months (include skin and non-prescription medications):

Are you in good general health? _____ Yes No

Do you take antibiotics prior to surgical/dental procedures? _____ Yes No

Are you pregnant or planning pregnancy? _____ Yes No

Do you have, or have you ever had, any of the following problems? Please check all that apply:

- Diabetes
- Liver disease (e.g. hepatitis)
- Asthma
- Kidney disease
- HIV disease
- Eczema
- Problems with healing or scarring
- Allergies (e.g. hayfever)
- Psoriasis
- Heart disease
- Hypertension
- Thyroid or other endocrine disorders
- G.I. ulcers
- Immunosuppression
- Glaucoma
- Anemia or any blood disorders (including use of blood thinners)
- Auto-immune disorders or connective tissue/ rheumatologic disorders (e.g. lupus)

Please provide additional information regarding above disorders or any other disorders: _____

Have you recently experienced any of the following symptoms? Please circle yes or no:

- | | |
|--|--|
| Headaches, dizziness, faintness, weakness or numbness? _____ Yes No | Shortness of breath? _____ Yes No |
| Double or blurred vision, dry or irritated eyes? _____ Yes No | Productive cough? _____ Yes No |
| Chest pain, palpitations, or swelling of the ankles? _____ Yes No | Abnormal bleeding? _____ Yes No |
| Muscle aches, arthralgias or arthritis? _____ Yes No | Fatigue, aches or joint stiffness/pain? _____ Yes No |
| Sinus problems, earaches or difficulty hearing? _____ Yes No | Frequent urination or burning? _____ Yes No |
| Dry mouth, mouth ulcers, a sore throat, or nasal congestion? _____ Yes No | Weight gain or loss of more than 5 lbs? _____ Yes No |
| Heartburn, indigestion, or difficulty swallowing? _____ Yes No | Anxiety, depression or moodiness? _____ Yes No |
| Nausea and/or vomiting, constipation, diarrhea, abdominal pain? _____ Yes No | Fevers, sweats, or chills? _____ Yes No |

Do you drink alcohol?
 Rarely Occasionally/Socially (e.g. parties, special occasions) Regularly/Socially (e.g. a glass of wine daily) Never

Do you use, or have you ever used, tobacco products? _____ Yes No If yes, please specify: _____

Please check the statement that best describes your skin:
 Always burn/Never tan Always burn first, then tan slowly Rarely burn/Tan easily Never burn/Always tan

Have you spent a lot of time in the sun? _____ Yes No Have you ever used a tanning salon? _____ Yes No
Do you have a history of skin cancer? _____ Yes No Do you have a history of any other cancer? _____ Yes No

If yes, please specify: _____

Do you have a family history of skin cancer? _____ Yes No Do you have a family history of any other cancer? _____ Yes No

If yes, please specify: _____

Please list any recent surgeries: _____

Signature of patient/guardian _____

FOR OFFICE USE ONLY:

Provider Initials _____ Review date _____ Provider Initials _____ Review date _____

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