

SANFORD DERMATOLOGY

John D. Cheesborough, MD • Dawn Kleinman, MD
Corynn Sloyer, PA-C • Mary Candace Seagle, PA-C

HEALTH QUESTIONNAIRE

Date: _____

Name: _____ Age: _____ Date of Birth: _____

Referred By: _____

Primary Care Physician: Dr. _____ Phone: _____

Reason for Visit (One or Two Main Problems to Address Today): _____

Duration of Problem: _____

Treatment: _____

Aggravating factors: _____

Current Medications (please include OTC, herbs, vitamins, supplements): _____

Allergies to Medication: None _____

Other Allergies: None Latex Bandages/Adhesive

Topical Antibiotic (Neosporin or other) _____

Have you ever had any bad reaction to local anesthesia? No Yes Never had anesthesia

FOR WOMEN ONLY:

Are you currently pregnant, trying to become pregnant, or are you nursing? _____

Are you on a contraceptive, if so what form? _____

SKIN CONDITIONS:

Have you ever had skin cancer? No Yes

If Yes, Basal Cell Cancer Squamous Cell Cancer Melanoma

Where? _____ When? _____

Treatment? _____

Has anyone in your family ever had skin cancer? No Yes

If Yes, Basal Cell Cancer Squamous Cell Cancer Melanoma

Who? _____

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Do you have a history of any skin problems or diseases? No Yes

If Yes, Psoriasis Eczema Keloid Other _____

SUN EXPOSURE:

When you are exposed to the sun do you:

- | | |
|---|--|
| <input type="checkbox"/> always burn | <input type="checkbox"/> rarely burn, always tan well |
| <input type="checkbox"/> usually burn, tan minimally | <input type="checkbox"/> very rarely burn, tan very easily |
| <input type="checkbox"/> sometimes mild burn, tan uniformly | <input type="checkbox"/> never burn, tan very easily |

Where did you grow up? _____

Did you have: sunburns every summer in childhood

at least one blistering sunburn, how many _____

ever use a tanning bed, how many times/how often _____

regular sunscreen use, SPF _____

PAST SURGERIES (Type and Date): _____

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS:

Allergic/Immunologic: Normal Seasonal allergies Immunosuppression

Autoimmune problem

Constitutional: Normal Weight loss/weight gain Fever/Nightsweats Fainting

Cancer: Type _____

Cardiovascular: Normal Artificial Heart Valve Pacemaker

Implanted Defibrillator Irregular Heartbeat

Chest Pain/Heart attack Mitral Valve Prolapse

Other _____

Ears/Eyes/Nose: Normal Glaucoma Glasses/Contacts Other _____

Endocrine: Normal Diabetes Thyroid Disease Other _____

Gastrointestinal: Normal Reflux Liver Problem Nausea Diarrhea

Other _____

Genital/Urinary: Normal Enlarged Prostate Prostate Cancer

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Hematologic: Normal Anemia Bleeding Problems Other _____

Infections: Normal HIV Hepatitis Tuberculosis/+PPD Skin Test
 Other _____

Musculoskeletal: Normal Arthritis Artificial Joint Other _____

Neurological: Normal Stroke Seizures/Epilepsy Multiple Sclerosis
 Other _____

Respiratory: Normal Asthma Emphysema Other _____

Psychiatric: Normal Depression Anxiety Attacks Other _____

Others: Kidney Problems Cold Sores Varicose Veins
 Require Antibiotics Prior to Dentistry

Any other medical problems: _____

FAMILY HISTORY: Eczema Psoriasis Other _____

SOCIAL HISTORY:

Marital Status: Single Married Divorced Widow/Widower

Occupation: _____

Smoking: No Former Yes, packs/day

_____ **Alcohol:** No Yes, how much/often

By signing, I am acknowledging that I have disclosed all of my health information known to me at this time, and all of my other personal information is accurate. I understand that it is my obligation and responsibility to notify Sanford Dermatology of any changes in my medical information during the course of my medical treatment.

❖ SIGNATURE _____ Date _____