SANFORD DERMATOLOGY

John D. Cheesborough, MD • Dawn Kleinman, MD
Nicole Lindsey, 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

<u>FOR WOMEN ONLY:</u>

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

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

<u>SKIN CONDITIONS:</u>

Have you ever had skin cancer? ☐No ☐Yes

If Yes, ☐Basal Cell Cancer ☐Squamous Cell Cancer ☐Melanoma

Where? ____**When?** __________________________________

Treatment? ____

Has anyone if your family ever had skin cancer? ☐No ☐Yes

If Yes, ☐Basal Cell Cancer ☐Squamous Cell Cancer ☐Melanoma

Who? ____

827 S. Horner Blvd. • Sanford, NC • 27330
(919) 775-7926 • (919) 718-0092 Fax

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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:

☐ **always burn** ☐ **rarely burn, always tan well**
☐ **usually burn, tan minimally** ☐ **very rarely burn, tan very easily**
☐ **sometimes mild burn, tan uniformly** ☐ **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 ___________________

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