Date: _____/_____/_____

HEALTH HISTORY QUESTIONNAIRE

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

Name: *(Last, First, M.I.)*	☐ M ☐ F	**DOB:** _____/_____/_____

PRESENT DERMATOLOGIC HEALTH CONCERN(S)

Please describe your current dermatologic problem(s) and why you are seeking consultation.

ILLNESSES (Check all that apply)

Have you ever been diagnosed with any of the following illnesses or medical problems? If yes, include approximate date or year.

☐ Abdominal Aortic Aneurysm	Date/Yr:	☐ HIV/AIDS	Date/Yr:
☐ Alzheimer's Disease	Date/Yr:	☐ Hodgkin's Disease	Date/Yr:
☐ Anemia	Date/Yr:	☐ Kidney Cancer	Date/Yr:
☐ Angina	Date/Yr:	☐ Kidney Stones	Date/Yr:
☐ Asthma/Bronchitis	Date/Yr:	☐ Leukemia	Date/Yr:
☐ Bladder Cancer	Date/Yr:	☐ Lung Cancer	Date/Yr:
☐ Breast Cancer	Date/Yr:	☐ Malignant Lymphoma	Date/Yr:
☐ Cardiac Arrhythmia	Date/Yr:	☐ Mitral Valve Prolapse	Date/Yr:
☐ Cerebrovascular Accident (Stroke)	Date/Yr:	☐ Multiple Sclerosis	Date/Yr:
☐ Cervical Cancer	Date/Yr:	☐ Osteoarthritis	Date/Yr:
☐ Cholelithiasis	Date/Yr:	☐ Ovarian Cancer	Date/Yr:
☐ Colon Cancer	Date/Yr:	☐ Padget's Disease	Date/Yr:
☐ Coronary Artery Disease	Date/Yr:	☐ Parkinson's Disease	Date/Yr:
☐ Cystocele/Rectocele	Date/Yr:	☐ Penile Cancer	Date/Yr:
☐ Deep Venous Thrombosis	Date/Yr:	☐ Prostate Cancer	Date/Yr:
☐ Depression	Date/Yr:	☐ Prostate Enlargement (BPH)	Date/Yr:
☐ Diabetes	Date/Yr:	☐ Prostatitis	Date/Yr:
☐ Diverticulosis/Diverticulitis	Date/Yr:	☐ Pulmonary Tuberculosis	Date/Yr:
☐ Emphysema	Date/Yr:	☐ Seizures	Date/Yr:
☐ Erectile Dysfunction (ED)	Date/Yr:	☐ Testis Cancer	Date/Yr:
☐ Genital Condyloma	Date/Yr:	☐ Transient Ischemic Attack (TIA)	Date/Yr:
☐ Genital Herpes	Date/Yr:	☐ Thyroid Disease	Date/Yr:
☐ Glaucoma	Date/Yr:	☐ Ulcerative Colitis	Date/Yr:
☐ Gout	Date/Yr:	☐ Urinary Incontinence	Date/Yr:
☐ Heart Attack	Date/Yr:	☐ Urinary Tract Infection	Date/Yr:
☐ Heart Failure	Date/Yr:	☐	Date/Yr:
☐ Heart Murmur	Date/Yr:	☐	Date/Yr:
☐ Hepatitis	Date/Yr:	☐	Date/Yr:
☐ Hiatal Hernia	Date/Yr:	☐	Date/Yr:
☐ High Blood Pressure	Date/Yr:	☐	Date/Yr:

OPERATIONS

Please list all surgeries including approximate date or year.

Surgery	Diagnosis	Date/Yr.

MEDICATIONS

Please list your prescribed drugs and over-the-counter drugs, such as vitamins and nutritional supplements including approximate start date.

Name of Drug	Strength	Frequency Taken	Start Date/Yr.

ALLERGIES

Please list all drug allergies including type of reaction.

Drug	Type Reaction

PERSONAL HISTORY AND HEALTH HABITS

Marital Status	☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow		
Religion			
Occupation			
Physical Activity	☐ Non-Ambulatory	☐ Limited-Mobility	☐ Inactive
	☐ Walking	☐ Running	☐ Swimming
	☐ Aerobic Training	☐ Strength Training	☐ Recreational Activities
	☐ Other		
Dietary	☐ Regular	☐ Diabetic	☐ Weight Reduction
	☐ Low Fat	☐ Renal Failure	☐ Weight Gain
	☐ Vegetarian	☐ Gluten Free	☐ Lactose Free
	☐ Other		

Advance Directive	☐ None	☐ Living Will	☐ Surrogate
Alcohol	☐ None		
	☐ Beer (drinks/wk): _____	Duration: _____ years	Date Discontinued: _____
	☐ Wine (drinks/wk): _____	Duration: _____ years	Date Discontinued: _____
	☐ Liquor (drinks/wk): _____	Duration: _____ years	Date Discontinued: _____
Tobacco	☐ None		
	☐ Cigarette (pks/day): _____	Duration: _____ years	Date Discontinued: _____
	☐ Cigar (#/day): _____	Duration: _____ years	Date Discontinued: _____
	☐ Pipe (#/day): _____	Duration: _____ years	Date Discontinued: _____
	☐ Chew (#/day): _____	Duration: _____ years	Date Discontinued: _____
	☐ Snuff (#/day): _____	Duration: _____ years	Date Discontinued: _____
Drugs	☐ None		
	☐ Marijuana (#/day): _____	Duration: _____ years	Date Discontinued: _____
	☐ Cocaine (#/day): _____	Duration: _____ years	Date Discontinued: _____
	☐ Other (#/day): _____	Duration: _____ years	Date Discontinued: _____

FAMILY HEALTH HISTORY

☐ **No History of Familial Disease**

Relative (i.e., Father, Mother, Uncle, Sister, etc.)	**Illness** (i.e., Diabetes, Heart Disease, Prostate Cancer, etc.)

REVIEW OF SYSTEMS (Check all that apply)

General	☐ Anorexia	☐ Chills	☐ Fatigue
	☐ Fever	☐ Malaise	☐ Sweats
	☐ Weight Loss		
Eyes	☐ Blurred Vision	☐ Double Vision	☐ Eye Pain
	☐ Eye Discharge	☐ Vision Loss	☐ Eye Irritation
Ears, Nose, and Throat	☐ Decreased Hearing	☐ Ringing in Ears	☐ Ear Pain
	☐ Hoarseness	☐ Pain with Swallowing	☐ Nose Bleeds
Cardiovascular	☐ Chest Pain	☐ Peripheral Edema	
	☐ Palpitations		
Respiratory	☐ Cough	☐ Wheezing	☐ Bloody Sputum
	☐ Shortness of Breath		
Gastrointestinal	☐ Abdominal Pain	☐ Nausea	☐ Vomiting
	☐ Diarrhea	☐ Constipation	☐ Tarry Stools
	☐ Bloody Stools		
Genitourinary	☐ Painful Urination	☐ Blood in Urine	☐ Sexual Dysfunction
	☐ Difficulty Voiding	☐ Urinary Incontinence	

Musculoskeletal	☐ Back Pain ☐ Muscle Weakness	☐ Joint Pain	☐ Joint Swelling
Skin	☐ Dryness ☐ Suspicious Lesion	☐ Itching	☐ Rash
Neurological	☐ Dizziness ☐ Seizures	☐ Weakness	☐ Tremors
Psychiatric	☐ Depression ☐ Hallucinations	☐ Anxiety	☐ Memory Loss
Endocrine	☐ Cold Intolerance ☐ Weight Change	☐ Heat Intolerance	☐ Increased Thirst
Hematologic and Lymphatic	☐ Abnormal Bruising	☐ Easy Bleeding	☐ Enlarged Lymph Nodes
Allergic and Immunologic	☐ Hay Fever	☐ Itching	☐ HIV Exposure

CERTIFICATION

The above information is true to the best of my knowledge.

X		
	Patient/Legal Guardian/Authorized Person (Signature)	Date of Signature