



DERMATOLOGY
& CUTANEOUS SURGERY

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HEALTH QUESTIONNAIRE

DATE: _____ DOB: _____ AGE: _____ WT: _____ HGT: _____ SEX: MALE _____ FEMALE _____

PATIENT NAME: _____
LAST FIRST MIDDLE

REASON FOR THE VISIT: _____

DURATION OF CONDITION: _____

TREATMENT TRIED: _____

LIST ALL ALLERGIES TO MEDICATIONS: _____

LIST HOSPITALIZATIONS / SURGERIES: _____

COSMETIC SURGERIES / PROCEDURES: _____

MEDICAL CONDITIONS:

LIST ALL MEDICATION / VITAMINS TAKEN DAILY:

BIRTH WEIGHT: _____ APGAR: _____

FEMALES ONLY

ARE YOU PREGNANT?: YES _____ NO _____ HOW MANY WEEKS: _____ BIRTH CONTROL METHOD? _____

NUMBER OF PREGNANCIES: _____ ARE YOU BREAST FEEDING? YES _____ NO _____

ARE YOU PLANNING TO GET PREGNANT: YES _____ NO _____ WHEN? _____

REGULAR MENSTRUAL PERIOD: YES _____ NO _____ DATE OF THE LAST MENSTRUAL PERIOD: _____ / _____ / _____

MENOPAUSAL SYMPTOMS OF POSTMENOPAUSAL? YES _____ NO _____ AGE OF ONSET: _____

SOCIAL HISTORY

WORK STATUS: EMPLOYED _____ UNEMPLOYED _____ OCCUPATION: _____

LIVE ALONE: YES _____ NO _____ HOBBIES: _____

DO YOU HAVE PETS? YES _____ NO _____ SCHOOL / DAYCARE? YES _____ NO _____

SMOKE: YES _____ NO _____ WHAT DO YOU SMOKE? _____ HOW OFTEN? _____

ALCOHOL CONSUMPTION: YES _____ NO _____

HOW OFTEN? DAILY _____ SOCIALLY _____ OCASIONALLY _____ NEVER _____

DO YOU USE ANY RECREATIONAL DRUGS? _____

SEXUALLY ACTIVE WITH ONE PARTNER: _____ SEXUALLY ACTIVE WITH MORE THAN ONE PARTNER: _____