PATIENT LEGAL NAME:______________________________ DATE OF BIRTH:_________ DATE:________

MEDICAL QUESTIONNAIRE

REASON FOR SCHEDULING APPOINTMENT:____

Do you have now, or have you ever had diseases or conditions of: **If you are unsure, enter "?"**

SKIN DISEASE HISTORY:	**YES**	**NO**		**YES**	**NO**
Acne	❒	❒	Flaking or Itchy Scalp/	❒	❒
Actinic Keratosis /Precancerous spots	❒	❒	Hay Fever/Allergies	❒	❒
Asthma	❒	❒	Melanoma	❒	❒
Basal Cell Carcinoma	❒	❒	Poison Ivy	❒	❒
Blistering Sunburns	❒	❒	Precancerous Moles	❒	❒
Dry Skin	❒	❒	Psoriasis	❒	❒
Eczema	❒	❒	Squamous Cell Carcinoma	❒	❒

When exposed to sun do you: ❒Tan only ❒Tan and Burn ❒Burn

	YES	**NO**	
Do you tan in a tanning salon?	❒	❒	❒ Have in the past.
Do you wear sunscreen?	❒	❒	If "YES", which SPF? ❒15 ❒30 ❒45 ❒50 ❒______
Do you have a family history of skin cancer?	❒	❒	If "Yes", which relative?-______________________________
Do you have a family history of Melanoma?	❒	❒	If "Yes", which relative?-______________________________

LIST ANY OTHER SKIN CONDITIONS:____

MEDICATIONS: Please list all current medications, supplements and vitamins; or provide a detailed list of current medications.

❒SEE ATTACHED or ❒NONE

____

____

ALLERGIES:

Have you ever had any bad reaction to dental anesthesia? ❒ No ❒ Yes ❒ Uncertain

Are you allergic to any medications? ❒ No ❒ Yes, If "yes", list: ______________________________

Are you allergic to any foods? ❒ No ❒Yes, If "yes", list: ______________________________

MISCELLANEOUS HISTORY:

Do you smoke? ❒ Current every day smoker ❒ Former Smoker ❒ Never Smoked

Do you drink alcohol? ❒ No ❒Yes, If "yes", how many drinks per day?_______________________

Do you use IV drugs? ❒ No ❒Yes, If "yes", list what and how much_______________________

RACE: ❒ American Indian or Alaska Native ❒ Black or African American ❒ Native Hawaiian or Other Pacific Islander
❒ Asian ❒ White ❒ Other, enter race ________________________

ETHNIC GROUP: ❒ Hispanic or Latino ❒ NOT Hispanic or Latino

PREFERRED LANGUAGE: ❒ English ❒ Other ________________________

PRIMARY CARE PHYSICIAN: ____________________________ ❒NONE

PREFERRED PHARMACY:_________________________ City/Street/Location:_________________________

PREFERRED EMAIL ADDRESS:____________________________

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PATIENT LEGAL NAME:______________________________ **DATE OF BIRTH:**__________ **DATE:**________

Do you have now, or have you ever had diseases or conditions of: **PAST MEDICAL HISTORY-If you are unsure, enter "?"**

	YES	NO		YES	NO
Anxiety	❒	❒	Heart Attack-Myocardial infarction	❒	❒
Arthritis/Joint Deformity	❒	❒	Hearing Loss	❒	❒
Asthma	❒	❒	Heart Murmur	❒	❒
Atrial Fibrillation	❒	❒	Hepatitis-Inflammatory disease of the liver	❒	❒
Bladder	❒	❒	High Blood Pressure-Hypertention	❒	❒
Bone Marrow Transplantation	❒	❒	High Cholesterol-Hypercholesterolemia	❒	❒
Breast Cancer	❒	❒	HIV/AIDS	❒	❒
Colon Cancer	❒	❒	Irregular Heartbeat	❒	❒
COPD-Chronic obstructive pulmonary disease	❒	❒	Leukemia	❒	❒
Coronary Artery Disease-arteriosclerosis	❒	❒	Lung Cancer	❒	❒
Depression	❒	❒	Lymphoma	❒	❒
Diabetes	❒	❒	Prostate Cancer	❒	❒
Emphysema	❒	❒	Radiation Treatment	❒	❒
End Stage Renal Disease	❒	❒	Seizures	❒	❒
GERD-Gastro-esophagael reflux disease	❒	❒	Stroke-Cerebrovascular accident	❒	❒
Glaucoma	❒	❒	Thyroid Problems	❒	❒

NONE ❒

Do you have any other medical problems, diseases or conditions not listed above? ❒ No ❒ Yes

If "yes", please list:____

PAST SURGICAL HISTORY	YES	NO		YES	NO
Appendix Removed	❒	❒	Kidney Biopsy (Nephrectomy)	❒	❒
Bladder Removed-cystectomy	❒	❒	Kidney Replacement (Right, Left)	❒	❒
Mastectomy (Right, Left, Bilateral)	❒	❒	Kidney Stone Removal-extraction of	❒	❒
Lumpectomy (Right, Left, Bilateral)	❒	❒	Kidney Transplant	❒	❒
Breast Biopsy	❒	❒	Ovaries Removed- Endometriosis	❒	❒
Breast Reduction-Reduction mammoplasty	❒	❒	Ovaries Removed- Cyst	❒	❒
Breast Implants	❒	❒	Ovaries Removed- Ovarian Cancer	❒	❒
Colectomy: Colon Cancer Resection	❒	❒	Prostate Removed- Prostate Cancer	❒	❒
Colectomy: Diverticulitis	❒	❒	Prostate Biopsy	❒	❒
Colectomy: IBD-Inflammatory bowel disease	❒	❒	TURP (Prostate Removal)-Prostatectomy	❒	❒
Gallbladder Removed-cholecystectomy	❒	❒	Spleen Removed-history of splenectomy	❒	❒
Coronary Artery Bypass	❒	❒	Testicles Removed (Right, Left, Bilateral)	❒	❒
Mechanical Valve Replacement	❒	❒	Hysterectomy: Fibroids	❒	❒
Biological Valve Replacement	❒	❒	Hysterectomy: Uterine Cancer	❒	❒
Heart Transplant	❒	❒			
Joint Replacement-Hip (Right, Left, Bilateral)	❒	❒			
Joint Replacement-Knee (Right, Left, Bilateral)	❒	❒			
Joint Replacement within last 2 years	❒	❒			

OTHER SURGERIES:________________________________

____

NONE ❒

ALERTS:	YES	NO		YES	NO
Allergy to Adhesive	❒	❒	Defibrillator	❒	❒
Allergy to Lidocaine	❒	❒	MRSA	❒	❒
Allergy to Topical Antibiotics	❒	❒	Pacemaker	❒	❒
Artificial Heart Valve	❒	❒	Rapid heartbeat with epinephrine	❒	❒
Artificial Joint Replacement	❒	❒	Are you trying to get pregnant?	❒	❒
Blood Thinners	❒	❒	**Require antibiotics prior to a surgical procedure?	❒	❒

COVID 19 Vaccination Date(s) ________________________________ DECLINE TO VACCINATE ❒

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