DERMATOLOGY PATIENT QUESTIONNAIRE

BEST CONTACT NO: Daytime: _____ Cell: _____ Other: _____

REFERRING FRIEND / FAMILY / PHYSICIAN: _____

PHARMACY NAME & ZIP CODE: _____

DO YOU NEED REFILLS TODAY? □ Yes □ No. If yes, list medication(s): _____

REASON FOR YOUR VISIT: □ Mole □ Rash □ Other: _____
Located where: _____ For how long: _____
□ Bleeding □ Itching □ Painful □ Changing shape □ Changing color □ Changing size
Treatments, including medications, tried: _____

FOR RETURN PATIENTS ONLY: □ Check box if no changes from last visit

HAVE YOU EVER HAD:

Actinic keratosis	□ Yes □ No	Blistering sunburn	□ Yes □ No
Basal cell carcinoma	□ Yes □ No	Atypical/dysplastic nevus	□ Yes □ No
Squamous cell carcinoma	□ Yes □ No	Tanning bed use	□ Yes □ No
Melanoma	□ Yes □ No	Use sunscreen daily	□ Yes □ No
Other skin cancer	□ Yes □ No	Skin biopsy	□ Yes □ No

Family member with skin cancer: □ Yes □ No. If yes, list relationship & type: _____
_____

MEDICAL CONDITIONS (e.g., asthma, cancer, coronary artery disease, depression, diabetes, eczema, esophageal reflux, hay fever, hepatitis, high blood pressure, high cholesterol, HIV, lupus, psoriasis, rosacea, thyroid disease)

MEDICATIONS (including prescription, over-the-counter, herbal and vitamins). If there is an attached medication list, check ones that you are taking, cross out ones that you are not taking, and put a "?" next to ones about which you are unsure.

PREVIOUS SURGERIES & DATES

MEDICATION ALLERGIES: □ Yes □ No
If yes, list:

SOCIAL HISTORY
Are you □ Retired □ Working as _____
Are you a □ Non-smoker □ Former smoker □ Current smoker. If current, ___ packs/day for ____ years
Do you drink alcohol: □ Yes □ No. If yes, _____ drinks/day
Do you use recreational drugs: □ Yes □ No. If yes, list: _____

_____ _____
PATIENT SIGNATURE **DATE**

_____ _____
REVIEWED BY: **DATE**