PATIENT QUESTIONNAIRE

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

REFERRING FRIEND / FAMILY / PHYSICIAN / INTERNET: _____

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 MEDICARE PATIENTS ONLY:
Have you had: ☐ Flu shot ☐ Pneumonia vaccine
Did you bring a copy of your current medications: ☐ Yes ☐ No
Are you a: ☐ Non-smoker ☐ Former smoker ☐ Current smoker. If current, ___ packs/day for ___ years
Name of your surrogate decision maker: _____
Do you have: ☐ high blood pressure: If no, then BP: _____.

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).

☐ List attached

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/medical marijuana/drugs: ☐ Yes ☐ No. If yes, list: _____

PATIENT SIGNATURE **DATE**