PATIENT QUESTIONNAIRE

BEST CONTACT NO: Home: _____ Cell: _____ Other: _____

REFERRING PHYSICIAN / FAMILY / FRIEND / 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
Medication / treatment tried: _____
_____

FOR RETURN PATIENTS ONLY: □ Check if no changes since last visit, skip to the signature line & sign.

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 on face daily	□ Yes □ No
Other skin cancer	□ Yes □ No	Skin biopsy	□ Yes □ No

1st degree family relative (e.g., mother, father, brother, sister, children) with melanoma skin cancer:
□ Yes □ No. If yes, list relationship: _____

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**