DERMATOLOGY QUESTIONNAIRE v4.1

Welcome. Please help make the most of your visit by completing this form. Let us know if you need assistance in doing so.

NAME: ______________________ AGE: ________ DATE OF VISIT: ________ DATE OF BIRTH: ________

1. May we have your cell phone number? (To reach you for appointment reminders. lab results. etc.) (   ) ______________

2. Did another doctor (or health practitioner) send you? ☐ Yes ☐ No Dr./Practitioner Name: ______________
   Who is your regular doctor/practitioner (primary care)? ______________

3. Please list any allergies to medications, latex, tape, local anesthetics: ______________
   ☐ No known allergies to medications, latex, tape, local anesthetics, topical antibiotics (Neosporin), iodine/X-Ray contrast dye

4. Please list your current oral medications, and any injection medication or chemotherapy you are currently on, as well as aspirin, vitamins, supplements, etc. Dosage is not always necessary. If you keep a medication list we can make a copy of it.
   ☐ Not on any medications

5. If you have a rash, itchy skin, dry skin, acne, or questions about skin products, please list topical medications/products/soap/cleanser that you are currently using, or have used recently, or have used to treat the condition. If you have questions about specific nonprescription or cosmetic products, it is very helpful to bring them with you, with the complete list of ingredients. If you have a facial skin condition, or are here for skin cancer screening, ***please remove makeup prior to your exam.***

Topical Medications/Products	Where on body it is applied?	How often?	Any problems with it? Is it helpful?

Have you had eczema?........................ ☐ Yes ☐ No
Have you had psoriasis?........................ ☐ Yes ☐ No
Do you have a family history of eczema?.......... ☐ Yes ☐ No
Do you have a family history of psoriasis?.......... ☐ Yes ☐ No

6. Have you seen a dermatologist before?.................................... ☐ Yes ☐ No
   Have you had a skin biopsy/mole removal?.............................. ☐ Yes ☐ No
   Have you ever had a skin cancer?.. ☐ Yes ☐ No
   Type(s), if known: ______________
   Have you ever had a melanoma? (a specific type of cancer)?....... ☐ Yes ☐ No
   Have you had actinic keratoses ("precancers")?......................... ☐ Yes ☐ No
   Have any family members (blood relatives) had skin cancer?...... ☐ Yes ☐ No
   Have any family members (blood relatives) had melanoma?....... ☐ Yes ☐ No
   Have you had many sunburns or any blistering sunburns?.......... ☐ Yes ☐ No
   Have you had bad or blistering sunburn?.................................. ☐ Yes ☐ No
   Do you sunburn easily?.. ☐ Yes ☐ No
   Do you tan poorly?.. ☐ Yes ☐ No
   Do you tan easily?... ☐ Yes ☐ No
   Have you had a lot of sun exposure?.. ☐ Yes ☐ No
   Have you ever used a tanning bed or booth?............................ ☐ Yes ☐ No

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7. Please check or list any medical conditions, serious illnesses, major surgeries.

- ☐ Diabetes Mellitus (Type I or II)
- ☐ Hypertension
- ☐ Angina/Heart Attack/Bypass/Stent
- ☐ Stroke
- ☐ Asthma
- ☐ Tuberculosis/Positive Skin Test
- ☐ Immune Problem :______________
- ☐ Connective Tissue Disease
- ☐ Lupus
- ☐ Joint Replacement(s);______________
- ☐ Thyroid Problem:______________
- ☐ Heart Valve Problem:______________
- ☐ Heart Rhythm Problem:______________
- ☐ Emphysema / Chronic Bronchitis
- ☐ Stomach / Duodenal Ulcers
- ☐ Gastric-Esophageal Reflux (GERD)
- ☐ Depression
- ☐ Anxiety
- ☐ Bleeding Disorder:______________
- ☐ Attention Deficit / Hyperactivity
- ☐ Liver Problem:______________
- ☐ Kidney Problem
- ☐ Bladder Problems
- ☐ Cancer (other than skin):______________
- ☐ Seizures
- ☐ Memory Problems
- ☐ Currently Pregnant or Breastfeeding
- ☐ Major Surgeries:______________
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ Require antibiotics before dental work
- ☐ Other health issues that you think are important:______________

8. Do you try to tan your skin?.. ☐ Yes ☐ No
   Do you try NOT to tan your skin?.. ☐ Yes ☐ No
   Do you use sunscreen when outdoors?.. ☐ Yes ☐ No ☐ Sometimes
   Do you try to wear hat and/or long sleeves when outdoors?........ ☐ Yes ☐ No ☐ Sometimes
   Do you smoke or use any form of tobacco?................................ ☐ Yes ☐ No ☐ N/A (Young child)
   Have you recently used a tanning bed or booth?........................ ☐ Yes ☐ No

9. Are you feeling ill today?.. ☐ Yes ☐ No
   If yes, please give details: ______________________________

   Is your skin unusually sensitive to the sun (burning/rash with minimal sun exposure)?.................... ☐ Yes ☐ No
   Do you have any moles or skin growths that itch or bleed or have recently grown/changed?......... ☐ Yes ☐ No
   If yes, please give locations: ______________________________

10. Please list reasons for today's visit (problems or concerns with your skin), along with location, approximate duration (how long you have had it), symptoms (such as itching, growth/change of a mole, etc.), and any previous treatment(s):

Problem and Location	*Approximate Duration*	*Symptoms*	*Previous Treatments*

11. Please share your signature, so that we will be able to compare to it, if you ever request that your records be sent anywhere.

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Let us know which one or two problems are of most concern to you (and to your referring doctor). Depending on the number and type of skin problems and concerns, and on the amount of time scheduled for you, please understand that not all of the problems can always be addressed in one visit, especially if you were "worked in" for an urgent problem. Let us know if you have traveled a long distance for this appointment. If we keep you waiting today, we apologize. We try to stay on time, but delays are often unavoidable, due to the nature of medical practice. We try hard to give each person the attention he or she deserves.

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