# Patient History Questionaire

Name of Patient:____________________ DOB:____________ Age:_________

**Reason For Visit:** #1____________ #2______________ #3______________

| | #1 | #2 | #3 |
|---|---|---|---|
| Duration: | ____________ | ______________ | ______________ |
| Location: | ____________ | ______________ | ______________ |
| Severity: | Mild Mod Severe | Mild Mod Severe | Mild Mod Severe |
| Prev Treatments: | None OTCs____ ______________ | None OTCs_____ ______________ | None OTCs____ ______________ |
| Assoc. Symptoms: | None Pain Itching | None Pain Itching | None Pain Itching |

1. Please list all know Drug Allergies: ____________________________________

2. Please list all Medications both prescription and over the counter meds and/or herbal:______________________________________________________________

3. Do you have a PERSONAL history of skin cancer? Yes No If yes, what type?
Basal Cell Cancer Squamous Cell Cancer Melanoma Unknown

4. Past Medical conditions: (Please Circle) Eczema Asthma Hayfever
High Blood Pressure Heart Attack Thyroid Disease Stomach Ulcers TB
Lung Disease Hepatitis A, B, or C Abnormal Bleeding Keloids Diabetes

5. Please list previous Surgeries:_________________________________________

6. Do you have a FAMILY history of skin cancer? Yes No If yes, what type & who?
Basal Cell __________ Squamous Cell__________ Melanoma__________ Unknown

7. Do you have a blood relative with: Asthma Eczema Hayfever? Who?_________

8. Do you drink alcohol Yes No How much?_________________________

9. Are you: Divorced Separated Widowed Married Single
10. Do you use illegal/recreational substances? Yes No _________________
11. Do you have a history of a sexually transmitted disease? Yes No_________
12. Do you smoke? Yes No How much?_______________________________

13. Review of Systems:

| | | | |
|---|---|---|---|
| Cough: | Yes | No | |
| Fever: | Yes | No | |
| General Overall Health: | Excellent | Good | Poor |
| Seasonal Rhinitis: | Yes | No | |
| Recent Weight Loss: | Yes | No | |
| Wheezing: | Yes | No | |