HEALTH HISTORY QUESTIONNAIRE

Fairhaven Dermatology

NAME: _____ DOB: _____ DATE:_____

Primary Care Physician (PCP): _____

Referring Physician, if different from PCP: _____

Preferred Pharmacy: _____ City: _____ Street: _____

If you are 65 or older, do you have a healthcare proxy in the event you are unable to make your own medical decisions. ◎ **Yes** ◎ **No**

Past Medical History:

- ☐ None
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (A-fib)
- ☐ Cerebrovascular accident (stroke)
- ☐ Chronic obstructive lung disease (COPD)
- ☐ Coronary arteriosclerosis (heart disease)
- ☐ Depressive disorder
- ☐ Diabetes Mellitus
- ☐ Elevated blood pressure (hypertension)
- ☐ End stage renal disease
- ☐ Epilepsy
- ☐ History of hypertension
- ☐ HIV
- ☐ Hypercholesterolemia
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Malignant tumor colon (colon cancer)
- ☐ other _____

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Past Surgical History:

- ☐ None
  - ☐ History of colectomy (removed colon)
  - ☐ Mechanical heart valve replacement
- ☐ other _____

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Skin Disease History:

- ☐ None of the below
  - ☐ Actinic Keratosis
  - ☐ Basal Cell Skin Cancer
  - ☐ Melanoma
  - ☐ Squamous cell carcinoma
  - ☐ other _____

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Family history of melanoma? ☐ Yes ☐ No

If yes, which relative? _____

Medications: Please list all of your medications below. ☐ NONE

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: Please list any allergies to medications below. ☐ NO KNOWN DRUG ALLERGIES

_____	_____	_____

Social History:

Smoking status: ☐ Current ☐ Former ☐ Never

Alcohol: ☐ <1 per day ☐ 1-2 per day ☐ 3 or more per day ☐ None

Family History:

Please list any medical conditions in your family.

_____

_____

_____

Current Review of Symptoms: (mark all that apply) ☐ **NONE OF THE BELOW**

- ☐ rash
- ☐ immunosuppression
- ☐ hay fever
- ☐ chest pain
- ☐ fever or chills
- ☐ night sweats
- ☐ unintentional weight loss
- ☐ thyroid problems
- ☐ sore throat
- ☐ blurry vision
- ☐ abdominal pain
- ☐ bloody stool
- ☐ bloody urine
- ☐ joint aches
- ☐ muscle weakness
- ☐ neck stiffness
- ☐ headaches
- ☐ seizures
- ☐ cough
- ☐ shortness of breath
- ☐ wheezing
- ☐ anxiety
- ☐ depression
- ☐ allergy to adhesive
- ☐ allergy to latex
- ☐ allergy to lidocaine
- ☐ allergy to topical antibiotic ointments
- ☐ blood thinners
- ☐ problems with bleeding
- ☐ problems with healing
- ☐ problems with scarring (hypertrophic or keloids)
- ☐ artificial heart valve
- ☐ artificial joints within past 2 years
- ☐ defibrillator
- ☐ pacemaker
- ☐ need premedication prior to procedures
- ☐ pregnant or planning a pregnancy
- ☐ History of MRSA