DERMATOLOGY HISTORY QUESTIONAIRE **Initial____** **Follow up____**

Name_____**Age**_____ **Date**_____

Name of primary care doctor_____

Do you have, or have you ever been treated for, any of the following:

Accident or trauma Yes____ No____
Aphthous (mouth) ulcers Yes____ No____
Asthma Yes____ No____
Bleeding disorder Yes____ No____
Cancer Yes____ No____
Cataracts Yes____ No____
Colitis or intestinal diseases Yes____ No____
Diabetes Yes____ No____
Eczema Yes____ No____
Emotional or psychiatric problems Yes____ No____
Glaucoma Yes____ No____
Hay fever Yes____ No____
Heart disease Yes____ No____
Herpes infection Yes____ No____
Herpes Zoster (Shingles) Yes____ No____
HIV+ Yes____No____
Hives Yes____No____
Hypertension Yes____No____
Immunodeficiency Yes____No____
Kidney disease Yes____No____
Liver or gallbladder disease Yes____No____
Lyme disease Yes____No____
PACEMAKER Yes____No____
Peptic ulcer disease, Yes____No____
Psoriasis Yes____ No____
Recurrent bladder infections Yes____No____
Sinusitis or sinus infections Yes____No____
Skin cancer Yes____No____
Tuberculosis or lung disease Yes____No____
Other illness_____
_____

Major surgery
Procedure_____Year_____
Procedure_____Year_____
Procedure_____Year_____

Hospitalization
Illness_____Year_____
Illness_____Year_____

Allergy
Environmental:
Pollen _____Dust_____Latex_____
Nickel_____ Chemical sensitivity_____
Mercury amalgam fillings_____
Mold exposure_____
Foods: Dairy_____Gluten_____Other_____
Drugs: Penicillin____ Aspirin____ Codeine_____

Social history Occupation_____
Addictions: Cigarettes____ Alcohol____
Drugs_____ Sugar____
Family history Heart disease____ Cancer____
Skin cancer_____

Blood type: A_____ B_____ O_____ AB_____

Recent vaccinations: Hepatitis____ Flu____ Other____

For Women:
Recurrent vaginal yeast infections Yes____No____
Pregnant or planning pregnency
Yes____No____

Current prescription medicines:
_____
_____
_____
_____

History of taking:
Steroids____ Antibiotics____ Chemotherapy____

Over the counter medicines, vitamins or herbal products:
_____
_____
_____
_____

Have you had the following?

Difficulty with wound healing_____
Excessive bleeding when cut_____
Overgrown scars or keloids_____
Allergic reactions to local anesthetics_____
Fever blisters or cold sores_____
Root canals_____

Skin Symptoms:

Itching_____ Dandruff_____ Hives_____
Brittle or soft Nails_____ Cracking fingertips____
White spots on fingernails____ Hair falling____
Skin feels coarse____ Dark pigmentation_____
Thickened soles of feet_____ Dry skin_____
Excessive sweating_____

General symptoms:
Height_____ Weight_____
Recurrent infections____ Chronic pain ____
Fatigue____ Recent weight gain or loss ____
Joints swollen or stiff ____

Difficulty loosing weight____ or gaining weight____
Frequently on a diet____ Crave sweets____

Burning epigastric pain_____ Hot flushes____
Diarrhea____ Consipation____ Gas pains____

Feeling usually too cold ____ or too hot__
Anemia____ Heavy menstrual bleeding____
PMS____ Depression____ Dizzyness___