CLAYTON DERMATOLOGY GROUP

MEDICAL HISTORY QUESTIONNAIRE

1. Please enter the following:

First Name: _____ Middle: _____ Last name:_____

Street Address: _____

City: _____ State: _____ Zip: _____

Mobile phone: _____ Alternate Phone: _____

Email address: _____ Date of Birth: _____

Social Security Number: _____ Male_____ Female _____

Emergency Contact:_____ Phone:_____

Primary Care Physician:_____Phone:_____

City: _____ State: _____ Zip:_____

Pharmacy Name: _____ Location:_____

Patient Name: _____ Date of Birth: _____

2. Medical History (Please check all that apply)

☐ Anxiety	☐ Depression	☐ Hyper/Hypothyroidism
☐ Arthritis	☐ Diabetes	☐ Leukemia
☐ Asthma	☐ Enlarged Prostate	☐ Lung cancer
☐ Atrial Fibrillation	☐ GERD	☐ Lymphoma
☐ Bone Marrow Transplant	☐ Hearing Loss	☐ Prostate Cancer
☐ Breast Cancer	☐ Hepatitis B or C	☐ Radiation Treatment
☐ Colon Cancer	☐ Elevated Blood Pressure	☐ Renal Disease
☐ COPD	☐ High Cholesterol	☐ Seizures
☐ Coronary Artery Disease	☐ HIV/AIDS	☐ Stroke

If other, please specify: _____

3. Past Surgical History

	Surgery	Date
1		
2		
3		

4. Skin History (Please check all that apply)

☐ Dysplastic Nevi/Abnormal moles	☐ Acne	☐ Eczema
☐ Actinic Keratoses (precancers)	☐ Psoriasis	☐ Poison Ivy
☐ Basal Cell Carcinoma	☐ Asteatosis cutis (dry skin)	
☐ Squamous Cell Carcinoma	☐ Hay Fever/ Seasonal Allergies	
☐ Flaking or itchy scalp	☐ Blistering Sunburn	
☐ Keloids/Hypertrophic scarring	☐ Malignant Melanoma	

If other, please specify: _____

Do you wear sunscreen? ☐ Yes ☐ No

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of melanoma? ☐ Yes ☐ No

If yes, please specify which family member: _____

Patient Name: _____ Date of Birth: _____

5. Medications (Please list all your medications, including vitamins and supplements, doses and frequencies)

	Medication	Dose	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

☐ I am **NOT** currently taking any medications.

6. Allergies (Please include any medication allergies and the type of reaction that occurred)

	Allergy	Reaction
1		
2		
3		

7. ROS/Alerts (Please check any of these important alerts if they apply to you)

☐ Allergy to adhesive
☐ Allergy with Epinephrine
☐ Artificial joints (last 2 years)
☐ Pregnancy/Nursing
☐ Allergy to topical antibiotics
☐ Problems with scarring (Hypertrophic or keloid)
☐ Allergy to lidocaine
☐ Artificial heart valve
☐ Transpiant History
☐ Rash
☐ Vasovagal/fainting with procedures
☐ Latex Allergy
☐ Blood thinners
☐ Pacemaker/Defibrillator
☐ Problems with healing
☐ Premedication prior to procedures

If other, please specify: _____

Patient Name: _____ Date of Birth: _____

8. What is your current/former occupation? _____

9. Do you smoke?

☐ Never ☐ Former ☐ Current

10. How many drinks containing alcohol do you consume per day?

☐ 0 ☐ 1-2 drinks/day ☐ 3 or more

11. Have you received a flu vaccine this season?

☐ Yes ☐ No

12. If over 65, have you received a pneumonia vaccine?

☐ Yes ☐ No ☐ N/A