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
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Enlarged Prostate
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis B or C
- ☐ Elevated Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hyper/Hypothyroidism
- ☐ Leukemia
- ☐ Lung cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Renal Disease
- ☐ Seizures
- ☐ 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
- ☐ Actinic Keratoses (precancers)
- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Flaking or itchy scalp
- ☐ Keloids/Hypertrophic scarring
- ☐ Acne
- ☐ Psoriasis
- ☐ Asteatosis cutis (dry skin)
- ☐ Hay Fever/ Seasonal Allergies
- ☐ Blistering Sunburn
- ☐ Malignant Melanoma
- ☐ Eczema
- ☐ Poison Ivy

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: ______________________________

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		
4		
5		

☐ I have **NO** allergies to medications

Patient Name: ______________________________ Date of Birth: __________

7. **What is your current/former occupation?** ______________________________

8. **Do you smoke?**

   ☐ Never ☐ Former ☐ Current

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

   ☐ 0 ☐ <1 drink ☐ 1-2 drinks ☐ 3 or more

10. **How many times this year have you had 4 or more drinks per day?**

    ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 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

13. **What is your height and how much do you weigh?**

    ☐ Height (ft,in)___'____" ☐ Weight (lbs)________

14. **Dermatology Alerts (Please check any of these important alerts if they apply to you)**

    ☐ Allergy to adhesive ☐ Allergy to lidocaine ☐ Allergy to latex

    ☐ Allergy with Epinephrine ☐ Artificial heart valve ☐ Blood thinners

    ☐ Artificial joints (last 2 years) ☐ Transplant History ☐ Pacemaker/Defibrillator

    ☐ Pregnancy/Nursing ☐ Rash ☐ Problems with healing

    ☐ Allergy to topical antibiotics ☐ Vasovagal/fainting with procedures ☐ Premedication prior to procedures

    ☐ Problems with scarring (Hypertrophic or keloid)

    If other, please specify: ______________________________