# CULLMAN DERMATOLOGY CLINIC, P.C.

## Health Questionnaire

**NAME:** _____ **DATE:** _____

**DOB:** _____ **PHARMACY:** _____

**MEDICAL HISTORY:** Please circle Y (YES) or N (NO). If YES, please give details.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Artificial Heart Valve: | Y or N | _____ | Diabetes: | Y or N | | HIV or AIDS: | Y or N | |
| Artificial Joint: | Y or N | _____ | Thyroid Disorder: | Y or N | | Liver Disease/Hepatitis: | Y or N | |
| Organ Transplant: | Y or N | _____ | Kidney Disease: | Y or N | | Osteoporosis: | Y or N | |
| Pacemaker/Defibrillator: | Y or N | _____ | Tuberculosis (TB): | Y or N | | Depression or Anxiety: | Y or N | |
| Cancer (other than skin): | Y or N | _____ | Exposure to TB: | Y or N | | History of Staph Infection: | Y or N | |

Other Medical History: _____

**SKIN HISTORY:**

Basal Cell Carcinoma: Y or N

Squamous Cell Carcinoma: Y or N

Abnormal Moles: Y or N

Melanoma: Y or N

Other Suspicious Lesion: Y or N

Psoriasis: Y or N

Keloids/Abnormal Scarring: Y or N

Other: _____

**SUN EXPOSURE HISTORY:** (Circle appropriate answer.)

Blistering Sunburns: 0 1-3 >3

Sunscreen Use: Never Sometimes Always

Tanning Bed Use: Never Previously Occasionally Regularly

**HABITS:** (Circle appropriate answer.)

Alcohol: Never Occasionally Daily

Smoking: Never Previously Occasionally Daily

Smokeless Tobacco: Y or N

**FAMILY HISTORY:** (If YES, please list type of relative.)

Melanoma: Y or N _____

Basal or Squamous Cell Carcinoma: Y or N _____

Breast Cancer: Y or N _____

Kidney Cancer: Y or N _____

Pancreatic Cancer: Y or N _____

Bleeding Disorder or Blood Clots: Y or N _____

Atopy (eczema, asthma, hay fever): Y or N _____

Psoriasis: Y or N _____

Rosacea: Y or N _____

Scarring Acne: Y or N _____

Other: _____

**OTHER INFORMATION:**

Marital Status: _____

Occupation: _____

Do you have an executed advanced directive? Y or N

Have You Ever Had an **Allergic Reaction** to:

Latex: Y or N

Local Anesthetics (ex. Lidocaine): Y or N

Surgical Tape or Adhesives: Y or N

Over-the-Counter Antibiotic Ointment: Y or N

**IMMUNIZATIONS:** (Please list the **month and year** of your most recent vaccinations.)

Influenza (Flu shot): _____

Pneumococcal (Pneumonia shot): _____

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