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

ALLERGIES: _____

MEDICATIONS: _____

_____

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