

ARLINGTON CENTER FOR DERMATOLOGY MEDICAL HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Today's Date:

Name <i>(Last, First, M.I.):</i>		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:
Address		City	Zip
Primary Phone Number:		Email:	
Social Security Number: _____ - _____ - _____			
This number will be used to uniquely identify you for any lab results, pharmacy verification or hospital admittance. This number is mandatory for hospital treatment and insurance filing.			
Responsible Party : <input type="checkbox"/> Self <input type="checkbox"/> Other-Name:		Responsible Party's Social Security Number :	
Address of Responsible Party if different than patient:			
What is your Occupation?		Employer Name:	
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Other			
How did you hear about our office (Referral from my Doctor, Yellow pages, Internet, from my insurance company, advertisement, friend or relative, other)?			Date of last physical exam:
Race: <input type="checkbox"/> American Indian or Alaska native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other Race <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Refuse to report			
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Refuse to report			
What is your primary complaint(s) today?			
Name of Previous or referring doctor:			
Pharmacy You Regularly USE (Name & Location):			
Allergies to medications <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:			
Name of the Drug:		Reaction had:	
List all prescribed drugs and over-the-counter medications you are currently taking, including aspirin, blood thinners, vitamins, etc.			
PERSONAL HEALTH HISTORY			
Check if you have, or have had, any of the following conditions. Briefly explain.			
<input type="checkbox"/> Stomach	<input type="checkbox"/> Bowel	<input type="checkbox"/> Heart Murmur	
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Arthritis or joint pain	<input type="checkbox"/> Bleed Easily	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Seizures	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Kidney	<input type="checkbox"/> Bladder	
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Fainting	<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Irregular Heartbeat			
<input type="checkbox"/> Convulsions, Epilepsy		<input type="checkbox"/> Chest Pain	
<input type="checkbox"/> Thyroid			
Do you use Antibiotic Prophylaxis for :		Do you have artificial joints?	Height _____
Dentistry <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight _____
Artificial Valves or Stints <input type="checkbox"/> Yes <input type="checkbox"/> No			

PLEASE TURN OVER AND COMPLETE BACK PAGE – THANK YOU

PERSONAL HEALTH HISTORY CONTINUED

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

GENERAL HEALTH QUESTIONS

When you are exposed to the sun, do you...	<input type="checkbox"/> Tan Only	<input type="checkbox"/> Tan & Burn	<input type="checkbox"/> Burn
Do you use tanning beds?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Any history of tanning beds?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you currently smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," how many packs per day? _____ Number of yrs smoked? _____. If "No" have you smoked in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ If "Yes" when did you last smoke _____	
Have you had skin cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If so, what type:			
Has anyone in your family had skin cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, what relation:			
Have you had any pancreatic cancers or other internal cancers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If so, what type:			
Has anyone in your family had pancreatic cancer, colon cancer other internal cancers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If so, what type and relation:			
Have you had any internal organ transplants or taken any Immunosuppressive drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If so, what type and when:			
Have you ever had a colonoscopy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes" what was the Year of your last colonoscopy? _____ Was it Abnormal? <input type="checkbox"/> Yes <input type="checkbox"/> No	

WOMEN ONLY

Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last menstruation:		
Are you trying to conceive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you experienced menopause?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, date menopause started:		

MEDICARE ONLY

Are you Disabled?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Briefly Explain:		

FULL BODY EXAMINATION

It is the policy of Arlington Center for Dermatology for medical providers to so a full body examination on all new patients. This ensures that no skin conditions go undetected and that you receive maximum benefit from your initial visit. If there is any part of your body you would **NOT** like examined, please indicate:

Check here if you would like to use one of our clinic's examination gowns

If you choose not to use a gown, please be prepared to disrobe quickly. If you need extra time to disrobe, please alert the Medical Assistant.