WCMC Department of Dermatology – Patient Exam Questionnaire

Patient Name: _____ **Patient Date of Birth**_____

Why are you here today? (Please list)

1. _____ 3. _____

2. _____ 4. _____

Please answer each of the following questions by checking off the appropriate box. Fill in explanation when necessary.

SOCIAL HISTORY

Do you smoke? ☐ NO ☐ YES How much? _____
Do you drink? ☐ NO ☐ YES How much? _____
Do you use IV drugs? ☐ NO ☐ YES
Have you had or have you been exposed to HIV (AIDS)? ☐ NO ☐ YES

ALLERGIES

Has your doctor ever requested you take antibiotics before a dental procedure? ☐ NO ☐YES
Are you **allergic** to any of the following?
Penicillin ☐ NO ☐ YES _____ **Sulfa** ☐ NO ☐ YES _____
Any other drugs? ☐ NO ☐ YES If **yes** what?_____
If yes, what type of reaction did you have?_____
Any foods? ☐ NO ☐ YES If **yes**, what?_____
Nail polish/cosmetics? ☐ NO ☐ YES If **yes**, what?_____

SKIN

Have you ever had a skin biopsy? ☐ NO ☐ YES If yes, when?_____Biopsy Site?_____
Have you ever had skin cancer? ☐ NO ☐ YES If yes, what type? _____
Any other form of cancer? ☐ NO ☐ YES If yes, what type?_____
Any abnormal skin moles? ☐ NO ☐ YES If yes, where? _____
Do you have a history of any skin diseases? ☐ NO ☐ YES If yes, what?_____
Do you bleed easily? ☐ NO ☐ YES
Do you develop keloid scars? ☐ NO ☐ YES
Has any one in your family ever had skin cancer? ☐ NO ☐ YES If yes, who? _____What type?_____

MEDICINES

Are you taking any medications (prescriptions, over-the-counter) regularly now? ☐ NO ☐ YES
If **yes**, fill out the following:

Name of medication	**Reason for taking this**

OPERATIONS AND HOSPITALIZATIONS

Have you ever been hospitalized? ☐ NO ☐ YES
If **yes**, fill out the following:

Date of hospitalization	**Reason for hospitalization**

SYSTEMS REVIEW

Do you have any of the following complaints?

GENERAL

Fatigue	☐ NO	☐ YES
Weight loss	☐ NO	☐ YES
Weakness	☐ NO	☐ YES
Swollen Lymph nodes	☐ NO	☐ YES
Easy bruising	☐ NO	☐ YES

HEAD

Visual problems	☐ NO	☐ YES
Ear pain, decreased hearing	☐ NO	☐ YES
Difficulty swallowing	☐ NO	☐ YES
Severe headaches	☐ NO	☐ YES
Strokes	☐ NO	☐ YES

Other _____

MEN ONLY

Hair growth or loss	☐ NO	☐ YES
Discharge from penis	☐ NO	☐ YES
Sore on penis	☐ NO	☐ YES

Other _____

CHEST, HEART AND LUNGS

Shortness of breath	☐ NO	☐ YES
Chest pain or pressure attacks	☐ NO	☐ YES
Frequent cough	☐ NO	☐ YES
Swollen ankles	☐ NO	☐ YES
Valve disorder	☐ NO	☐ YES

Other _____

_____

GASTROINTESTINAL

Poor appetite	☐ NO	☐ YES
Indigestion or vomiting	☐ NO	☐ YES
Change in bowel habits	☐ NO	☐ YES
Pass blood from rectum	☐ NO	☐ YES

Other _____

ENDOCRINE

Thyroid condition	☐ NO	☐ YES
Diabetes	☐ NO	☐ YES

Other ☐ NO ☐ YES_____

GENITALIA (WOMEN ONLY)

Breast lump	☐ NO	☐ YES
Discharge from nipple	☐ NO	☐ YES
Vaginal discharge or spotting (not from period)	☐ NO	☐ YES
hot flashes	☐ NO	☐ YES
Change in periods	☐ NO	☐ YES
Are your periods irregular?	☐ NO	☐ YES
Possibly pregnant	☐ NO	☐ YES

Number of times pregnant _____

Number of children _____

KIDNEY

Difficulty in passing urine	☐ NO	☐ YES
Getting up at night to urinate	☐ NO	☐ YES

Other _____

NEUROMUSCULAR

Weakness in arms or legs	☐ NO	☐ YES
Dizzy spells	☐ NO	☐ YES
Fainting spells	☐ NO	☐ YES

Other _____

_____

BONES/JOINTS

Painful or swollen ankles	☐ NO	☐ YES
Loss of muscle strength	☐ NO	☐ YES
Prosthetic bone replacements	☐ NO	☐ YES
Back pain	☐ NO	☐ YES

Other _____

ANY OTHER PROBLEMS OR CONCERNS? (PLEASE DESCRIBE)

_____

_____

_____

_____

_____ _____

Physician's Signature **Date**