

ARLINGTON CENTER FOR DERMATOLOGY MEDICAL HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your Medical Chart

Today's Date:

Name <small>(Last, First, M.I.):</small>	<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: / /
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Address	Apt#	City	Zip
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Primary Phone Number:	Email:
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Social Security Number: <input style="width: 500px; height: 25px;" type="text"/>	Marital Status: S M D W
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This number will be used to uniquely identify you for any lab results, pharmacy verification or hospital admittance. This number is mandatory for insurance filing & hospital treatment..

Responsible Party : <input type="checkbox"/> Self or <input type="checkbox"/> Other-Name:	Responsible Party's Social Security Number :
Other Party's Phone Number:	Responsible Party Date of Birth:
Address of Responsible Party if different than patient:	

Patient Occupation?	Employer Name:
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Race: <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Refuse to Report <input type="checkbox"/> Other _____	Ethnicity: Please check one <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Refuse to report	Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Other _____
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Emergency Contact Name: Relationship:	Emergency Contact Phone:
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How did you hear about our office? *(Referral from my Doctor, Yellow pages, Internet, from my insurance company, advertisement, friend or relative, etc.)*

What is your primary complaint(s) today?

Name of Previous or referring doctor: _____ Date of last physical exam: _____

Pharmacy regularly used (Name & Location):

Allergies to Medications <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If yes, please list</small>	Reaction
Name of the Drug	
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•	

List all Medications that you are currently taking <small>(Aspirin, Blood thinners, Vitamins, etc.)</small>	
•	•
•	•
•	•

PERSONAL HEALTH HISTORY

Check if you have, or have had, any of the following conditions. Briefly explain.

<input type="checkbox"/> Stomach	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Arthritis or joint pain	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Asthma	<input type="checkbox"/> Seizures	<input type="checkbox"/> Bleed Easily
<input type="checkbox"/> Allergies	<input type="checkbox"/> Kidney	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Fainting	<input type="checkbox"/> Bladder
<input type="checkbox"/> Bowel	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Convulsions, Epilepsy	<input type="checkbox"/> Other:

Do you use Antibiotic Prophylaxis for : Dentistry <input type="checkbox"/> Yes <input type="checkbox"/> No Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Valves or Stints <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have artificial joints? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had your spleen removed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Height _____ Weight _____
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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"/> Only Tan	<input type="checkbox"/> Tan & Burn	<input type="checkbox"/> Only Burn
Have you ever used tanning beds?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> When:
Do you Currently Smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Packs per day:
Have you had skin cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer Type:
Has anyone in your family had skin cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer Type: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Sibling
Have you had any melanoma or pancreatic cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer Type:
Have you had any colon cancer or other internal cancers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer Type:
Have any of your family members been diagnosed with melanoma or pancreatic cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer Type: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Sibling
Have any of your family members been diagnosed with colon cancer or other internal cancers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer Type: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Sibling
Have you had any internal organ transplants or taken any Immunosuppressive drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Other:
Have you ever had a colonoscopy?	Year of last colonoscopy?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Was it abnormal?		

WOMEN ONLY

Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Other:
Are you trying to conceive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Other:
Have you experienced menopause	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Symptoms Started:
Last date of menstrual cycle?			

MEDICARE ONLY

Are you disabled?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Other:
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Briefly Explain:**FULL BODY EXAM (OPTIONAL)**

It is the policy of Arlington Center for Dermatology for Medical Providers to do 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 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.