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 *(Last, First, M.I.):* ☐ M ☐ F **Date of Birth:** / /

Address **Apt#** **City** **Zip**

Primary Phone Number: **Email:**

Social Security Number:

This number will be used to identify you for any lab results, pharmacy verification or hospital admittance. This number is mandatory for insurance filing & hospital treatment..

Marital Status: **S M D W**

Insurance Company Name: **Member ID:** **Group ID**

Medical Claim Address (on back of card) **Name of Primary Policy Holder:**

Responsible Party For Minors: **Responsible Party's Phone Number:**

Address of Responsible Party if different than patient: **Responsible Party Date of Birth:**

Patient Occupation? **Employer Name:**

Race:
☐ **Asian** ☐ **African American** ☐ **Caucasian** ☐ **Hispanic**
☐ **American Indian or Alaska Native**
☐ **Native Hawaiian or Other Pacific Islander**
☐ **Refuse to Report** ☐ **Other** ________________________

Ethnicity:
Please check one
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Refuse to report

Preferred Language:
☐ English ☐ Spanish
☐ Vietnamese ☐ Chinese ☐ Hearing Impaired
☐ Other ___________________

Emergency Contact Name: **Emergency Phone:** **Relationship:**

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 Primary Care Physician (PCP) or referring doctor: **Date of last physical exam:**

Pharmacy regularly used ***(Name & Location):***

Allergies to Medications ☐ **Yes** ☐ **No** If yes, please list

Name of the Drug	Reaction
▪	
▪	

List all Medications that you are currently taking (Aspirin, Blood thinners, Vitamins, etc.)

▪	▪
▪	▪
▪	▪

PERSONAL HEALTH HISTORY

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

☐ Stomach	☐ Chest Pain	☐ Thyroid
☐ Bronchitis	☐ Hepatitis	☐ Heart Murmur
☐ Emphysema	☐ Arthritis or joint pain	☐ Glaucoma
☐ Asthma	☐ Seizures	☐ Bleed Easily
☐ Allergies	☐ Kidney	☐ Diabetes
☐ Chronic Cough	☐ Fainting	☐ Bladder
☐ Bowel	☐ Cancer	☐ High Blood Pressure
☐ Irregular Heartbeat	☐ Convulsions, Epilepsy	☐ **Other:**

Do you use Antibiotic Prophylaxis for :
Dentistry ☐ Yes ☐ No
Mitral Valve Prolapse ☐ Yes ☐ No
Artificial Valves or Stints ☐ Yes ☐ No

Do you have artificial joints?
☐ Yes ☐ No
Have you had your spleen removed?
☐ Yes ☐ No

Height ____________

Weight ____________

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

Question			
When you are exposed to the sun, Do you…	☐ Only Tan	☐ Tan & Burn	☐ Only Burn
Have you ever used tanning beds?	☐ Yes	☐ No	☐ When:
Do you Currently Smoke?	☐ Yes	☐ No	Packs per day:
Have you had skin cancer?	☐ Yes	☐ No	Cancer Type:
Has anyone in your family had skin cancer?	☐ Yes	☐ No	Cancer Type: ☐ Father ☐ Mother ☐ Sibling
Have you had any melanoma or pancreatic cancer?	☐ Yes	☐ No	Cancer Type:
Have you had any colon cancer or other internal cancers?	☐ Yes	☐ No	Cancer Type:
Have any of your family members been diagnosed with melanoma or pancreatic cancer?	☐ Yes	☐ No	Cancer Type: ☐ Father ☐ Mother ☐ Sibling
Have any of your family members been diagnosed with colon cancer or other internal cancers?	☐ Yes	☐ No	Cancer Type: ☐ Father ☐ Mother ☐ Sibling
Have you had any internal organ transplants or taken any Immunosuppressive drugs?	☐ Yes	☐ No	☐ Other:
Have you ever had a colonoscopy? ☐ Yes ☐ No	Year of last colonoscopy? Was it abnormal?		

WOMEN ONLY

Question			
Are you pregnant or breastfeeding?	☐ Yes	☐ No	☐ Other:
Are you trying to conceive?	☐ Yes	☐ No	☐ Other:
Have you experienced menopause	☐ Yes	☐ No	Symptoms Started:
Last date of menstrual cycle?			

MEDICARE ONLY

Question			
Are you disabled?	☐ Yes	☐ No	☐ Other:

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.