KEYSTONE DERMATOLOGY & CENTER FOR SKIN SURGERY

New Patient Health History Questionnaire

Please fill out the following Dermatology Questionnaire so that we can serve you better. Thank You!

Name_____ DOB _____ Soc Sec #_____
For Children: Name of Parents/Guardian: _____
Address_____
Home Phone_____ Cell Phone _____ Work Phone_____
Male/Female (Circle One) Height: _____ Weight: _____ Race:_____
Marital Status: (Circle One) Married/Single /Divorced /Widow /Other
Primary Care Physician:_____ How did you hear about our office?_____
Preferred Pharmacy Name: _____ Location: _____
Power of Attorney (POA) Name & Number (if applicable):_____
Has your blood pressure been checked in the past year? Y/N - Reading? _____ (If unknown – normal? Y/N)
What is the purpose of your visit today? _____
Any **allergies** to medications, latex, or adhesive: _____
Are you currently enrolled in HOSPICE? Y/N

List All Medications and Vitamins/Herbals (***no need to handwrite***, if you have a list please give it to receptionist to copy):
_____ _____ _____
_____ _____ _____

Please circle one for each of the following:
Does the patient drink alcohol? Never, Rarely, Socially, If Daily - circle one: Beer, Liquor, Wine (How many:_____)
Does the patient use any illicit or street drugs? Yes or No
Does the patient use tobacco? Yes (Packs per day: ____) Previously, Never
Does the patient Live with a smoker? Yes or No If yes, inside or outside the home?
Has the patient ever had skin cancer? Yes or No If yes, types:_____
Has anyone in patient's family had skin cancer? Yes or No If yes, who/what?_____
Does the patient have a history of any skin disease? Yes or No If yes, what?_____
Has the patient ever been exposed to Infectious disease? Yes or No If yes, explain:_____
Does the patient have artificial joints? Yes or No What Month/Year_____
Has the patient EVER had dental anesthesia ie. novacaine? Yes or No, Reactions?_____
Does the patient bleed easily? Yes or No
Are you currently pregnant, trying to become pregnant, or breastfeeding? Yes or No

Circle if you have any of the following: Artificial Heart Valves / Pacemaker / Defibrillator / Aneurysms/ MVP / Rheumatic Fever / Fever / Chills / Abnormal thyroid / Diabetes / Dizziness / Headaches / Blindness / Blurred vision / Nasal Congestion / Nasal Drainage

Personal History of any other major medical issues?
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