DermAssociates, PC • Patient Questionnaire

ver 1.22.11

Patient's name	Date of Birth:	Today's date
Current occupation or hobbies:		
Reason for visit:		

Social Habits:

Y	N		
		Smoking	If yes: ______ packs per day
		Alcohol	If yes: how much _______________
		Other	

Allergies to Medications: (If none please write NONE)

1.	3.	5.
2.	4.	6.

Medications:

Y	N		Additional Medications	6.
		Aspirin 81mg	1	7.
		Aspirin 325mg	2.	8.
		Coumadin	3.	9.
		Plavix	4.	10.
		Vitamin E	5.	11.

Review of Systems:

Y	N	Review of Systems	Y	N	Do you have any of the following?
		Fatigue			Rgtuqpcn"J kuvqt{ "of Skin Cancer
		Weight loss			History of Melanoma
		Muscle weakness			Previous Surgeries
		Bladder or Kidney trouble			Pacemaker0"Kh"{gu."y j gpA
		Liver problems			Defkdtknncvqt0"Kh"{gu."y j gpA
		Bleeding or bruising			Artificial jointu0"Kh"{gu"y j gpA
		Anxiety			HIV
		Depression			Hepatitis
		Headaches			High blood pressure
		Cancer			Previous skin biopsies
		Lupus			Family history of skin cancer
		Diabetes			Family history of any skin condition
		Photosensitivity			Latex Allergy

Please comment on any questions you answered **YES** above: