TARRANT DERMATOLOGY CONSULTANTS
MEDICAL QUESTIONNAIRE

Referred by: Dr. (name)

____

Date: ____________________________________

Name: ___________________________________

Date of Birth: _________________ Age: _____

Ht:____________ Wt:______________

Medical History:

Reason for visit: ____

How long have you had this problem? ____

Symptoms (How does it bother you?) ____

Treatments you have tried: ____

Please list **all medications** you are **currently taking** (include over-the-counter): __________________________

____

____

Please list any **drugs** you are **allergic** to: ____

Preferred Pharmacy:____**Phone Number:**___________________

Medical Problems (mark if yes)

- ◻ Diabetes
- ◻ High blood pressure
- ◻ Heart disease
- ◻ Artificial joint/valve
- ◻ Asthma
- ◻ Other lung disease
- ◻ Depression
- ◻ Cancer, type ___________________
- ◻ Lupus
- ◻ Kidney disease
- ◻ Pacemaker
- ◻ Hepatitis, type ___________________
- ◻ Anemia
- ◻ Thyroid disease
- ◻ X-Ray Therapy
- ◻ History of long-term steroid use
- ◻ HIV
- ◻ Other liver disease
- ◻ Other (comments) ____

Past Surgeries (list) ____

Pregnant? ◻ Yes ◻ No

History of Skin Cancer? ◻ Yes ◻ No ◻ Melanoma ◻ Basal cell carcinoma ◻ Squamous cell carcinoma

Area of the body ___________________________ How treated? ____________________________________

History of Skin Disease, past or present: ______________________________

____

When you are exposed to sunlight, do you (check most applicable one):

- ◻ always burn
- ◻ often burn, tan slowly
- ◻ rarely burn, always tan
- ◻ usually burn, rarely tan
- ◻ sometimes burn, tan well
- ◻ never burn, deeply tan

Review of Systems (please mark which of the following symptoms you are currently having):

- ◻ Prone to Infection
- ◻ Vision
- ◻ Hearing
- ◻ Stuffy Nose
- ◻ Weight change
- ◻ Eyelid scale
- ◻ Dizziness
- ◻ Sinus pain
- ◻ Fever/sweats
- ◻ Faint
- ◻ Mouth sore/throat pain

- ◻ Chest pain
- ◻ Shortness of breath
- ◻ Nausea/vomiting
- ◻ Penile/vaginal pain
- ◻ Palpitations
- ◻ Cough/wheezing
- ◻ Abdomen pain
- ◻ Penile/vaginal discharge
- ◻ Bowel change
- ◻ Menstrual irregularity

- ◻ Lymph node swelling
- ◻ Weakness of body part
- ◻ Joint/muscle pain
- ◻ Painful urination
- ◻ Easy bleeding
- ◻ Numbness of body
- ◻ Back pain
- ◻ Change in urination freq.
- ◻ Blood clots
- ◻ Seizures
- ◻ Headaches
- ◻ Other _________________

- ◻ Rash
- ◻ Itchy skin
- ◻ Skin growths
- ◻ Bad scars (keloids)
- ◻ Dry skin
- ◻ Skin sores
- ◻ Hair/nail problems
- ◻ Skin color changes

Past, Family, and Social History

Is there a family history of:

- ◻ Melanoma
- ◻ Psoriasis
- ◻ Skin cancer
- ◻ Hair loss
- ◻ Asthma
- ◻ Diabetes
- ◻ Eczema
- ◻ Adult acne
- ◻ Hay fever
- ◻ Genetic disease

Other: ______________________________

Patient Occupation: ___________________________

Animals in the home? __________________________

Smoker? ◻ Yes ◻ No

Number of alcoholic drinks per week: ____________

Prior history of blood transfusion or IV drug use? ____

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Reviewed by: ___ ______________________________