APPT DATE_____

ADVANCED DERMATOLOGIC SURGERY, P.A.
ADS AMBULATORY SURGERY CENTER

MEDICAL HISTORY QUESTIONNAIRE

Patient's Name: _____ **Age:** _____ **Occupation:** _____

Reason(s) for your visit: _____

Referred by: _____ **Primary Care Doctor:** _____
(first and last name)

Duration of Symptoms? _____ Symptoms? _____

Aggravated by? _____ Relieved by? _____ Has the area been biopsied? Yes or No

Has area been treated previously? Yes or No If yes, by who? _____

How and when was it treated? _____

Do you have a history of skin cancer? Yes or No If yes, where and when? _____

DO YOU HAVE ANY DRUG ALLERGIES: ☐ YES ☐ NO
Please circle any *of the listed DRUG ALLERGIES: Clindamycin, Penicillin, Keflex, Sulfa, Amoxicillin, Codeine, Iodine, Adhesives, Latex, Levaquin. (list any others)*

Please list any medications, and the dosages, that you are currently using: prescription/non-prescription

Medication:	Dosage:	Medication:	Dosage:	Medication:	Dosage:

PATIENT'S MEDICAL HISTORY: **Please check the condition and indicate the year.**

☐ Artificial heart valve_____
☐ Congestive Heart Failure_____
☐ Pacemaker_____
☐ **DEFIBRILLATOR**_____
☐ Heart Disease_____
☐ Heart Attack/Angina_____
☐ Heart Murmur_____
☐ Irregular Heartbeat_____
☐ Stroke_____
☐ Seizures_____
☐ Headaches_____
☐ Sinus Disease_____
☐ **HEPATITIS**_____
Type/Acquired?_____

☐ **HIV POSITIVE**_____
☐ Resistant Infections_____
☐**ORGAN TRANSPLANT**
What organ?_____
☐ Anemia/Bleeding/ Clotting Disorder?_____
☐ **DIABETES**_____
Type?_____
☐ Joint Replacement_____
☐ Arthritis_____
☐ Hearing loss_____
☐ Hearing Aids_____
☐ Liver Disease_____
☐ Gallbladder Disease_____

☐ Kidney Stones_____
☐ Kidney Failure/Dialysis_____
☐ Enlarged Prostate_____
☐ Prostate Cancer_____
☐ Breast Cancer_____
☐ Mastectomy-which side?_____
☐ Tuberculosis_____
☐ Asthma_____
☐ COPD/Emphysema_____
☐ Supplemental Oxygen Use_____
☐ Thyroid Disease_____
☐ **CANCER OF ANY TYPE**____
☐ Glaucoma/Cataracts_____
☐ Macular Degeneration_____

MEDICAL HISTORY QUESTIONNAIRE -Page Two

Indicate the reason and year for surgeries/hospitalizations.(Exclude normal pregnancies)

Surgery:	Year:	Hospitalization:	Year:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REVIEW OF SYSTEMS: Please indicate below any current diseases or symptoms.

RISK FACTORS
- ☐ X-ray treatments
- ☐ Radiation
- ☐ UV light treatments
- ☐ Immunosuppression

CONSTITUTIONAL SYMPTOMS
- ☐ Infections
- ☐ Fever
- ☐ Lightheadedness/passing out
- ☐ Weight loss

ALLERGY
- ☐ Cough
- ☐ Itching

OPTHALMOLOGIC
- ☐ Wears Glasses
- ☐ Wears Contacts

ENT
- ☐ Decreased hearing
- ☐ Swollen glands

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid Disorder

RESPIRATORY
- ☐ Sleep Apnea
- ☐ Supplemental Oxygen Use
- ☐ Cough

CARDIOVASCULAR
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Angina

GASTROINTESTINAL
- ☐ Stomach Ulcer
- ☐ Colitis

HEMATOLOGIC
- ☐ Easy bruising
- ☐ Bleeding problems

GENITOURINARY
- ☐ Frequent urination
- ☐ Painful urination

MUSCULOSKELETAL
- ☐ Fibromyalgia
- ☐ Limb swelling

SKIN
- ☐ Poor healing
- ☐ Skin disorders
- ☐ Keloids

NEUROLOGICAL
- ☐ Paralysis
- ☐ Neuralgia/nerve pain
- ☐ Tingling/Numbness

PSYCHIATRIC
- ☐ Mental Illness
- ☐ Dementia
- ☐ Anxiety
- ☐ Depression

***FAMILY HISTORY*: Please indicate if any of your family members have had any of the following conditions.**

In the space provided, place an **M** for ***mother***, an **F** for ***father***, a **C** for ***child***, or **S** for a ***sibling***.

Diabetes: _____ Stroke: _____ Heart Disease: _____ High Blood Pressure: _____Allergies: _____
Abnormal Moles: _____ Skin Cancer: _____ Melanoma: _____Other Cancer: _____

***SOCIAL HISTORY*: Please check all that apply.**

MARITAL STATUS
☐ Married ☐ Widowed
☐ Single ☐ Divorced
Number of Children_____

Females, are you pregnant?
☐ yes ☐ no

Females, are you breastfeeding?
☐ yes ☐ no

EDUCATION LEVEL
- ☐ Highschool
- ☐ College
- ☐ Graduate Degree

ALCOHOL USE
Have you had a drink in the last year? ☐ yes ☐ no
If so, how often did you drink in the last year?_____
If so, how many drinks do you have on a typical day?___
If so, how often did you have more than 6 drinks on one occasion?_____

TOBACCO USE
☐ current smoker ☐ former smoker ☐ nonsmoker
If so, how many cigarettes a day?_____
If so, how soon do you smoke after waking up?_____
If so, are you interested in quitting?_____