Dermatology Center of Grand Rapids

HEALTH QUESTIONNAIRE

Date: _____

Update: _____

Update: _____

NAME: _____ Date of Birth: _____

TELEPHONE NUMBER to reach you with results*: _____

Primary Care Physician: _____

***May we leave medical information or test results on your voice mail?** □ **Yes** □ **No**

PERSONAL MEDICAL HISTORY: Please CHECK if you have ever had, and then CIRCLE any that you currently have)

General
□ Fainting
□ Fever/chills
□ Night sweats
□ Weight loss

Heart
□ Artificial valve
□ Cardiac stent
□ Chest pains
□ Congestive heart disease
□ Heart attack
□ Heart murmur
□ High BP
□ Implanted defibrillator
□ Pacemaker
□ Valve disease

Lungs
□ Asthma
□ COPD
□ CPAP
□ Emphysema
□ Positive TB test
□ Pulmonary embolism
□ Short of breath
□ Tuberculosis

Gastrointestinal
□ Acid Reflux
□ Colitis
□ Hepatitis
□ Ulcers

Endocrine
□ Diabetes
□ Thyroid disorder

Immune system
□ Auto-immune condition (type)
_____
□ HIV
□ Immunosuppress.

Muscles/bones
□ Arthritis (type)
_____
□ Artificial joints
□ Fibromyalgia
□ Gout
□ Muscle weakness
□ Spinal implant

Blood
□ Anemia
□ Bleed easily
□ Blood clots
□ Circulatory probl.
□ Raynaud's syndr.

Eyes, ears, nose, throat
□ Cataracts
□ Chronic cough
□ Cochlear implant
□ Contact lenses
□ Ear problems
□ Glaucoma
□ Hearing loss
□ Sinusitis

Reproduct./urinary
□ Dialysis
□ Hysterectomy
□ Birth Control
_____
□ Renal failure
□ Renal stent

Brain/nervous
□ CVA (stroke)
□ Epilepsy
□ Headaches
□ Migraines
□ Multiple sclerosis
□ Neuropathy
□ Numbness/tingling
□ Seizures
□ Tremors

Psychiatric
□ ADD/ADHD
□ Alzheimer's
□ Anxiety
□ Dementia
□ Depression
□ Schizophrenia

Other
□ Cancer (type)
_____
□ Organ transplant
_____
□ Other
_____
_____

SURGICAL/HOSPITALIZATION HISTORY (list all): _____

_____

VACCINATIONS: When was your last flu vaccination? ____/_____ (mo/yr) ____/_____ (mo/yr) ____/_____ (mo/yr)
Have you ever had the pneumococcal (pneumonia) vaccine? □ No □ Yes (at what age) _____
Have you been vaccinated for shingles? □ No □ Yes

FAMILY HISTORY: □ Arthritis □ Diabetes □ High BP □ Heart disease □ Lung disease □ Stroke □ Cancer □ Other (EXCEPT SKIN)

Explain any checkmarks (include relationship to you): _____

_____

PERSONAL SKIN TYPE: When exposed to sunlight, do you: □ Burn □ Burn then tan □ Tan only

PERSONAL SKIN HISTORY: Have you ever had (for checked items, list onset, duration, treatment)

□ Psoriasis _____ □ Eczema _____

□ Rosacea _____ □ Acne _____

□ Other (specify) _____

□ Chronic sun exposure _____

□ Tanning bed exposure _____

□ Severe sun/tanning exposure (bad burns) _____

□ Chronic x-ray treatment _____

□ Skin cancer (specify type) _____

FAMILY SKIN HISTORY: Mother _____ Father _____

Children/siblings_____

_____

OVER PLEASE

CURRENT HEALTH

NAME: ____ Date of Birth: ____________________

CURRENT PHARMACY: _________________________________ Phone # or location ________________

CURRENT MEDICATIONS: (Include creams, over the counter medications, herbals, vitamins, and all other supplements)

Name		Dose	How often
______________________	□ Oral □ Topical □ Patch □ Other ____________	______________	__________
______________________	□ Oral □ Topical □ Patch □ Other ____________	______________	__________
______________________	□ Oral □ Topical □ Patch □ Other ____________	______________	__________
______________________	□ Oral □ Topical □ Patch □ Other ____________	______________	__________
______________________	□ Oral □ Topical □ Patch □ Other ____________	______________	__________
______________________	□ Oral □ Topical □ Patch □ Other ____________	______________	__________
______________________	□ Oral □ Topical □ Patch □ Other ____________	______________	__________
______________________	□ Oral □ Topical □ Patch □ Other ____________	______________	__________
______________________	□ Oral □ Topical □ Patch □ Other ____________	______________	__________

Does your PCP recommend taking antibiotics before dental procedures? □ No □ Yes (name) ____________

ALLERGIES: □ Medications (specify below) □ Foods □ Environment □ Latex □ Local anesthetic

____

Do you use tobacco? □ No □ Cigarettes □ Other ____________ How much? ________ For how long? ________

Do you drink alcohol? □ No □ Wine □ Beer □ Liquor Number of drinks/week _____ Number of drinks/occasion _____

Do you have a history of substance abuse? □ No □ Yes (past) □ Yes (current) ______________________

CURRENT SKIN CONDITIONS/CONCERNS (specify onset, duration, any previous treatments):

1. ____
2. ____
3. ____
4. ____

Patient signature: ______________________________________ Date: ____________________

Responsible party signature: ________________________________ Date: ____________________

Update: ____________ ____________ Update: ____________ ____________

Date Patient initials Date Patient initials