Health Questionnaire

Patient : last name : _____ first name : _____ middle name : _____

Reason for Visit : _____

History of Skin Diseases : _____

Past Illinesses/Surgeries : _____

Drug Allergies : _____

Medications : _____

Do you have or have you ever had any of the following?

☐ Hearing problems	☐ Glaucoma	☐ Cataracts	☐ Nose Bleeds
☐ Sinus Trouble	☐ Hoarseness	☐ Hay Fever	☐ Asthma
☐ Hypertension	☐ Coronary Artery Disease	☐ Heart Murmur	☐ Heart Valve Problem
☐ Palpitations	☐ Irregular Pulse	☐ Varicose Veins	☐ Phlebitis
☐ Difficulty Swallowing	☐ Heartburn	☐ Peptic Ulcer	☐ Colitis
☐ Hepatitis	☐ Kidney Stones	☐ Prostate Problems	☐ Venereal Disease
☐ Herpes	☐ HIV	☐ Chlamydia	☐ Gonorrhea
☐ Recent Weight Loss	☐ Anemia	☐ Bruise Easily	☐ Cancer
☐ Thyroid Disease	☐ Seizures	☐ Stroke	☐ Migraines
☐ Arthritis	☐ Gout	☐ Artificial Joints	☐ Mental Illness
☐ Depression	☐ Tuberculosis	☐ Diabetes	

For Women :

Regular Menstrual Periods? ☐ Yes ☐ No

Number of Pregnancies : _____

Number of Live Births : _____

Number of Miscarriages : _____

Birth Control Method : _____

Menopause symptoms : ☐ Yes ☐ No

Skin Problems:

☐ Eczema	☐ Psoriasis	☐ Rash	☐ Abnormal Moles
☐ Hives	☐ Acne	☐ Frequent Sun Exposure	☐ Excessive Scarring
☐ Basal Cell Skin Cancer	☐ Squamous Cell Skin Cancer	☐ Melanoma Skin Cancer	☐ Actinic Keratosis (pre-skin cancer)
☐ Cold Sores	☐ Hair Loss		

What kind of products do you use? (Cleansers, Toners, Sunscreen, Antioxidants, Retinols, Etc.)

_____

_____

_____

Signature: _____ Date: _____