FIRSTCARE DERMATOLOGY OF WORCESTER, LLC

Health Questionnaire

NAME:______________________ DOB:__________ AGE:________ SEX:________

DO YOU HAVE ANY OTHER INSURANCE FOR YOUR MEDICATIONS? (MEDCO, CAREMARK, ETC.)

____

REFERRED BY: ______________________

REASON FOR TODAY'S VISIT: (chief complaint) ______________________

DURATION OF PROBLEM :______________________ Treatment: ______________________

ALLERGIES TO MEDICATION AND REACTION IF KNOWN: ______________________

PAST SURGERIES: (type and date) ______________________

LIST CURRENT MEDICATIONS or ☐ SEE ATTACHED: ______________________

DO YOU HAVE ANY PAST OR PRESENT PROBLEMS WITH: (review of systems)

	YES	NO	(if yes, explain)
Eyes	☐	☐	
Ears/Nose/Throat/Mouth	☐	☐	
Heart/Pacemaker	☐	☐	
Lungs	☐	☐	
Stomach/Bowels	☐	☐	
Kidneys/Liver	☐	☐	
Arthritis/Muscles	☐	☐	
Headaches/Seizures	☐	☐	
Depression/Anxiety	☐	☐	
Thyroid/Diabetes	☐	☐	
Blood/Bleeding Disorder	☐	☐	
High Blood Pressure	☐	☐	
HIV (Aids) or Hepatitis?	☐	☐	
Cancer?	☐	☐	
Other	☐	☐	

SKIN:

	YES	NO	(if yes, explain)
Have you ever had skin cancer?	☐	☐	
Do you have a history of any skin diseases?	☐	☐	
Do you have a history of asthma, eczema or seasonal allergies?	☐	☐	

FAMILY HISTORY:

	YES	NO	(if yes, explain)
Has anyone in your family had skin cancer	☐	☐	
Abnormal moles or melanoma	☐	☐	
Any specific skin disease?	☐	☐	
Asthma, eczema or allergies?	☐	☐	

SOCIAL HISTORY:

What is your occupation: ______________________

	YES	NO
Do you use sunscreen?	☐	☐
Do you smoke?	☐	☐

How much alcohol do you drink? ______________________

SIGNATURE______________________ DATE ______________