

Department of Dermatology & Cutaneous Surgery



Dear Patient,

Welcome to the University of South Florida Medical Clinic. Enclosed is a personal Health History Questionnaire. Please complete this form and bring it with you along with any pertinent medical records on your scheduled appointment date. We are looking forward to your visit.

Sincerely,

Department of Dermatology & Cutaneous Surgery

Physician: _____

Date: _____

Time: _____

NEW PATIENT QUESTIONNAIRE / YEARLY UPDATE

NAME: _____	DATE: _____
ADDRESS: _____	DATE OF BIRTH: _____
_____	TELEPHONE # _____
_____	FAX # _____
PRIMARY CARE DR: _____	TELEPHONE # _____
ADDRESS: _____	FAX # _____
_____	_____
DID A DR. SEND YOU TO US FOR A CONSULTATION? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, NAME & ADDRESS: _____	
DR.'s NAME: _____	TELEPHONE # _____
ADDRESS: _____	FAX # _____
_____	_____

ALLERGIES: _____

MEDICATIONS: _____

TOPICALS:

Latex	Yes	No	If yes, explain	_____
Tape	Yes	No	If yes, explain	_____
Ointment	Yes	No	If yes, explain	_____

CURRENT MEDICATIONS: _____

VITAMINS & HERBS: _____

(CC) REASON FOR VISIT: _____	
(HPI) LOCATION OF PROBLEM: _____	Please use diagram on reverse side
DURATION OF PROBLEM: _____	SEVERITY: _____
TRIGGERS OF PROBLEM: _____	_____
PREVIOUS TREATMENTS: _____	_____

(PMH/ROS) DO YOU HAVE NOW OR HAVE HAD A HISTORY OF THE FOLLOWING CONDITIONS?

Cardiovascular:			Gastroenterology:								
Heart murmur mitral valve prolapse	Yes	No	Ulcers	Yes	No	Musculoskeletal:	Yes	No	Arthritis	Yes	No
Artificial Valves	Yes	No	Difficulty Swallowing	Yes	No	Muscle Weakness	Yes	No			
Heart Stents	Yes	No	Inflammatory Bowel	Yes	No	Eyes:			Impaired Vision	Yes	No
Pacemaker	Yes	No	Behcet's Disease	Yes	No	Cataracts	Yes	No	Light Sensitivity	Yes	No
Defibrillator/AICD	Yes	No	Liver Disease	Yes	No	Glaucoma	Yes	No	Ears/ Nose/ Mouth:		
Arrhythmia	Yes	No	Genitourinary:			Tinnitus	Yes	No	Vertigo	Yes	No
Congestive Heart Failure	Yes	No	Kidney Stones	Yes	No	Mouth Sores	Yes	No	Nasal congestion/discharge	Yes	No
Angina /chest pains	Yes	No	Kidney Failure	Yes	No	Hematologic/ Lymphatic			Blood borne pathogens	Yes	No
Coronary Artery Disease	Yes	No	Allergic/ Autoimmune:			Hepatitis	Yes	No	Blood Cancers (ex. Leukemia)	Yes	No
High or low blood pressure	Yes	No	Asthma	Yes	No	Chemotherapy	Yes	No	Radiation Therapy	Yes	No
Heart Attacks	Yes	No	Hayfever	Yes	No	Internal Cancers	Yes	No	Bleeding Disorders	Yes	No
Rheumatic Fever	Yes	No	Lupus	Yes	No						
Bypass Surgery	Yes	No	Hives	Yes	No						
Respiratory/ Pulmonary:			Neurologic:								
Shortness of Breath	Yes	No	Stroke	Yes	No						
Asthma	Yes	No	Seizures	Yes	No						
Emphysema /Bronchitis	Yes	No	Bell's Palsy	Yes	No						
Tuberculosis	Yes	No	Nerve weakness	Yes	No						
Endocrine:			Psychiatric:								
Diabetes Mellitus	Yes	No	Panic Attacks	Yes	No						
Thyroid Disease	Yes	No	Other	Yes	No						
Skin:											
Photosensitivity	Yes	No									
Skin Pre-Cancers	Yes	No									
Melanoma	Yes	No	If yes, explain:	_____							
Skin Cancer	Yes	No	If yes, explain:	_____							
Skin Surgery	Yes	No	If yes, explain:	_____							
Cosmetic Surgery	Yes	No	If yes, explain:	_____							

(SH) DO YOU PERSONALLY USE THE FOLLOWING:

Sunscreen	Yes	No	Alcohol	Yes	No	Tobacco	Yes	No
-----------	-----	----	---------	-----	----	---------	-----	----

(FH) DO ANY FAMILY MEMBERS HAVE A HISTORY OF THE FOLLOWING CONDITIONS?

Melanoma	Yes	No	Skin Cancer	Yes	No	Other skin diseases	Yes	No
----------	-----	----	-------------	-----	----	---------------------	-----	----

SIGNATURE: _____	REVIEWED BY: _____
(Patient or Guardian)	

NEW PATIENT QUESTIONNAIRE / YEARLY UPDATE

Please mark the areas relating to your skin problem.

