

NEW PATIENT/PRE-OPERATIVE QUESTIONNAIRE

| PRIMARY CARE DR: DR'S ADDRESS: | DR'S TELEPHON DR'S FAX #: | | | |
|---|--|--------|----|--|
| DID A DR. SEND YOU TO US FOR A CONSULTATION? □Yes □No IF YES, please PRIMARY CARE DR: DR'S ADDRESS: | e fill out this section: DR'S TELEPHON DR'S FAX #: | | | |
| SEND PRESCRIPTIONS ELECTRONICALLY TO PHARMACY? □Yes □No PHARMACY NAME: PHARMACY CROSS STREET: | PHARMACY PHO |)NE #: | | |
| CURRENT MEDICATIONS (INCLUDE HERBS/VITAMINS): | DO YOU HAVE AN ALLERGY TO: | | | |
| · · · · · · · · · · · · · · · · · · · | Latex | Yes | No | |
| | Tape | Yes | No | |
| | Ointment | Yes | No | |
| | Penicillin | Yes | No | |
| MEDICATION <u>ALLERGIES</u> (INCLUDE TOPICALS): | | | | |
| REASON FOR VISIT (Please mark on diagram on back also): | | | | |
| LOCATION OF PROBLEM: | DO YOU CURRENTLY USE: | | | |
| DURATION OF PROBLEM: | Sunscreen | | No | |
| TRIGGERS OF PROBLEM: | ARE YOU PRE BREAST FEEL | | R | |
| PREVIOUS TREATMENTS: | | Yes | No | |
| DO YOU HAVE NOW OR HAVE YOU HAD A HISTORY OF ANY OF THE FOLLOW | VING CONDITIONS? | | | |

| Cardiovascular: | | |
|--------------------------------|-----|----|
| Heart murmur | Yes | No |
| Artificial Valves | Yes | No |
| Mitral valve prolapse | Yes | No |
| Pacemaker/Defibrillator/AICD | Yes | No |
| High blood pressure | Yes | No |
| Arrhythmia | Yes | No |
| Congestive Heart Failure | Yes | No |
| Angina /chest pains | Yes | No |
| Coronary Artery Disease/Stents | Yes | No |
| Low blood pressure | Yes | No |
| Heart Attacks | Yes | No |
| Rheumatic Fever | Yes | No |
| Require Oxygen Tank | Yes | No |
| | | |
| Respiratory: | | |
| Shortness of Breath | Yes | No |
| Asthma | Yes | No |
| Emphysema /Bronchitis | Yes | No |
| Tuberculosis | Yes | No |
| | | |
| Endocrine: | | |
| Diabetes Mellitus | Yes | No |
| Thyroid Disease | Yes | No |
| | | |
| Psychiatric: | | |
| Panic Attacks | Yes | No |
| Depression | Yes | No |
| Bipolar Disorder | Yes | No |

| Gastroenterology: | | |
|-----------------------|-----|----|
| Ulcers | Yes | No |
| Difficulty Swallowing | Yes | No |
| Inflammatory Bowel | Yes | No |
| Behcet's Disease | Yes | No |
| Liver Disease | Yes | No |
| | | |
| Genitourinary: | | |
| Kidney Stones | Yes | No |
| Kidney Failure | Yes | No |
| | | |
| Allergic: | | |
| Hives | Yes | No |
| Hayfever | Yes | No |
| Eczema | Yes | No |
| | | |
| Neurologic: | | |
| Stroke | Yes | No |
| Seizures | Yes | No |
| Bell's Palsy | Yes | No |
| | | |
| Skin: | | |
| Pre-Cancers | Yes | No |
| Basal cell cancer | Yes | No |
| Squamous cell cancer | Yes | No |
| Melanoma | Yes | No |
| Atypical moles | Yes | No |
| Keloid/Thick Scars | Yes | No |
| MRSA Infections | Yes | No |

| Musculoskeletal: | | |
|-----------------------------|-----|------|
| Arthritis | Yes | No |
| Muscle Weakness | Yes | No |
| Artificial Joints | Yes | No |
| If yes, what year? | | |
| <i>V</i> / <i>V</i> | | |
| Eyes: | | |
| Impaired Vision | Yes | No |
| Light Sensitivity | Yes | No |
| Vision Changes | Yes | No |
| | | |
| Head/Ears/ Nose/ Mouth: | | |
| Tinnitus | Yes | No |
| Vertigo | Yes | No |
| Mouth Sores | Yes | No |
| Nasal congestion | Yes | No |
| Headaches | Yes | No |
| | | - 10 |
| Hematologic | | |
| Blood borne pathogens | Yes | No |
| HIV/AIDS | Yes | No |
| Hepatitis | Yes | No |
| Blood Cancers (Leukemia) | Yes | No |
| Internal Cancers | Yes | No |
| Chemotherapy | Yes | No |
| Radiation Therapy | Yes | No |
| Bleeding/Clotting Disorders | Yes | No |
| Immunosuppressed | Yes | No |
| Organ Transplant | Yes | No |

| Yes | No | | Vitamin E | Yes | No |
|-----|-------------------|----------------------|--------------------------------|--|---|
| Yes | No | | Retinoids | Yes | No |
| Yes | No | | Ginko Biloba/Herbs | Yes | No |
| Yes | No | | Implantable Medical Devices | Yes | No |
| Yes | No | | Alcohol | Yes | No |
| | Yes Yes Yes | Yes No Yes No Yes No | Yes No Yes No Yes No | Yes No Retinoids Yes No Ginko Biloba/Herbs Implantable Medical Devices | Yes No Retinoids Yes Yes No Ginko Biloba/Herbs Yes Yes No Implantable Medical Devices Yes |

| ANIBODI IN HOUR FAMILI | VIII: | |
|------------------------|-------|----|
| Melanoma | Yes | No |
| Asthma | Yes | No |
| Eczema | Yes | No |
| Lupus | Yes | No |
| Autoimmune disorders | Yes | No |
| | | |

| PATIENT SIGNATURE: |
|--------------------|
|--------------------|

REVIEWED BY:

Patient Identification

| University of South Florida |
|---|
| Department of Dermatology and Cutaneous Surgery |
| 12901 Bruce B Downs Blvd., MDC 79 |
| Tampa, FL 33612 |



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PLEASE MARK THE AREAS RELATING TO YOUR SKIN PROBLEM BELOW:

