NEW PATIENT/PRE-OPEARTIVE QUESTIONNAIRE

PRIMARY CARE DR: **DR'S TELEPHONE #:** ______________________
DR'S ADDRESS: **DR'S FAX #:** ______________________________

DID A DR. SEND YOU TO US FOR A CONSULTATION? ☐Yes ☐No **IF YES, please fill out this section:**
PRIMARY CARE DR: **DR'S TELEPHONE #:** ______________________
DR'S ADDRESS: **DR'S FAX #:** ______________________________

SEND PRESCRIPTIONS ELECTRONICALLY TO PHARMACY? ☐Yes ☐No
PHARMACY NAME: ____ **PHARMACY PHONE #:** ____________________
PHARMACY CROSS STREET: _______________________________________

CURRENT MEDICATIONS (INCLUDE HERBS/VITAMINS):

DO YOU HAVE AN ALLERGY TO:		
Latex	Yes	No
Tape	Yes	No
Ointment	Yes	No
Penicillin	Yes	No

MEDICATION ALLERGIES (INCLUDE TOPICALS): ________________________

REASON FOR VISIT (Please mark on diagram on back also):

LOCATION OF PROBLEM: ____

DURATION OF PROBLEM: ____

TRIGGERS OF PROBLEM: ____

PREVIOUS TREATMENTS: ____

DO YOU CURRENTLY USE:		
Sunscreen	Yes	No
ARE YOU PREGNANT OR BREAST FEEDING?		
	Yes	No

DO YOU HAVE NOW OR HAVE HAD A HISTORY OF THE FOLLOWING 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?		
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
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

DO YOU CURRENTLY USE:					
Aspirin	Yes	No	Vitamin E	Yes	No
Plavix	Yes	No	Retinoids	Yes	No
Coumadin	Yes	No	Ginko Biloba	Yes	No
Advil/Ibuprofen	Yes	No	Herbs	Yes	No
Tobacco	Yes	No	Alcohol	Yes	No

ANYBODY IN YOUR FAMILY WITH:		
Melanoma	Yes	No
Asthma	Yes	No
Eczema	Yes	No
Lupus	Yes	No
Autoimmune disorders	Yes	No

PATIENT SIGNATURE: ____ **REVIEWED BY:** ____

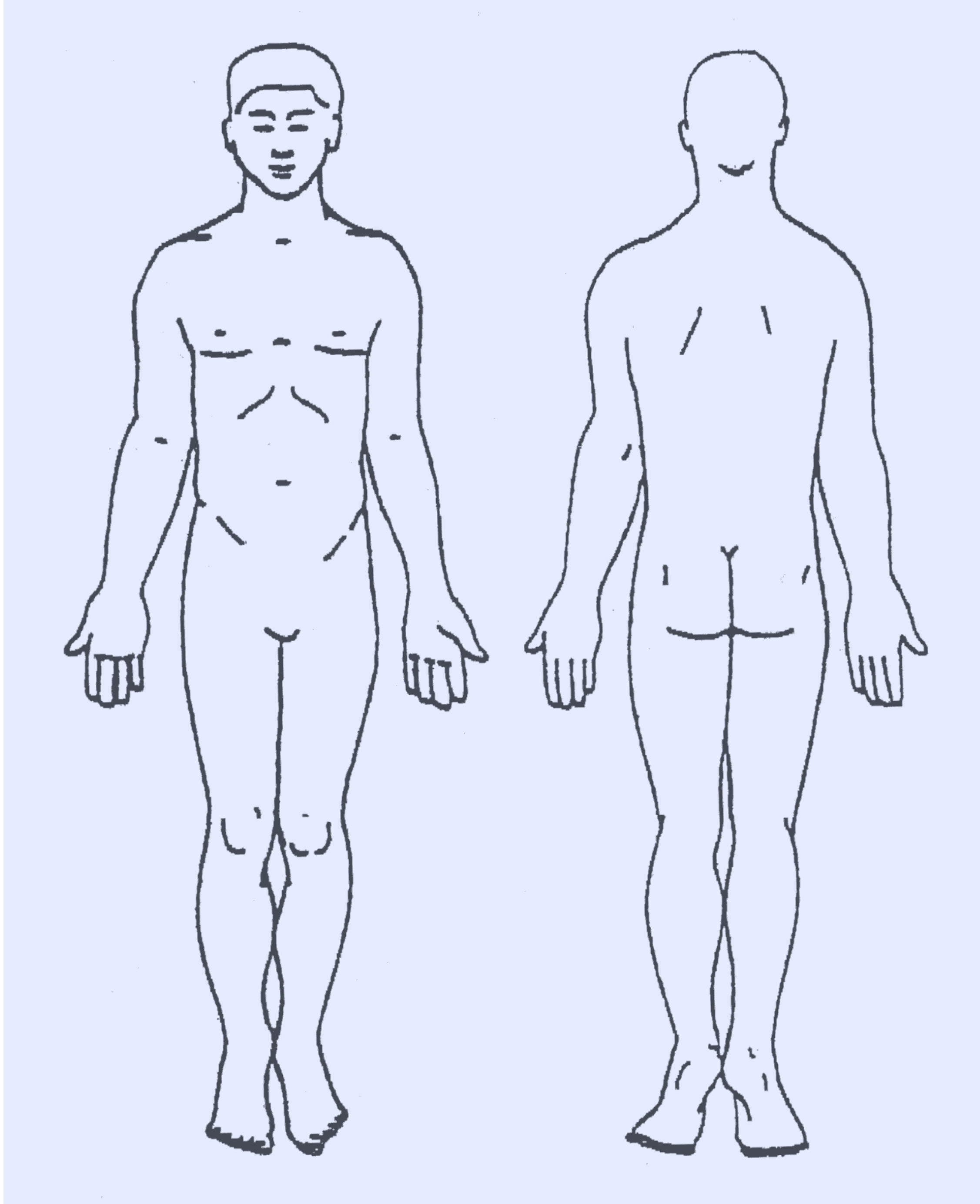
Patient Identification

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

USF HEALTH

NEW PATIENT/PRE-OPEARTIVE QUESTIONNAIRE

PLEASE MARK THE AREAS RELATING TO YOUR SKIN PROBLEM BELOW:



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