Medical Records Number

_____

Mountainview Skin Care, PC
216 Moore Road ♦ Suite 200 ♦ King, NC 27021
www.mtnviewskincare.com

Health Questionnaire

Name: _____ Date of Birth: _____ Date: _____

Referring Physician: _____ Previous Dermatologist: _____

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS:

1. What problem(s) or concern(s) brings you to the Dermatologist today? _____

   _____

2. How long has this problem(s) been present? _____

3. Describe any symptoms in the affected area:

   _____

4. Have you tried any medication or treatment for this problem? Yes No
   If yes, please list and indicate whether a specific treatment was helpful.

   _____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE OR HAVE HAD:

Anemia	Congestive Heart Failure	Kidney Disease
Angina	Diabetes	Liver Disease/Hepatitis
Anxiety/Depression	Emphysema (COPD)	Organ Transplant
Arrhythmias	GI Disorders	Pacemaker
Arterial Graft	Glaucoma	Prostate Enlargement
Arthritis	Heart Attack	Radiation Treatment
Artificial Heart Valve	Heart Murmur	Rheumatic Fever
Artificial Joint(s)	Heart Surgery	Skin Disease
Asthma/Bronchitis	High Blood Pressure	Stroke/ TIA
Bleeding Disorder	Immune System Problems	Sun Sensitivity
Cancer	Infections (HIV/TB)	Thyroid Disease
Cancer (Skin*)		

Other: _____

* If you have had a skin cancer, what type? _____

List previous illnesses and operations: _____

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS:

1. Do you drink alcohol? Yes No

2. Do you use tobacco? Yes No

3. Has anyone in your family ever had skin cancer? Yes No
   If yes, who and what type? _____

4. Have you ever had a reaction to local anesthesia? Yes No
   If yes, please describe: _____

5. Are you required to take antibiotics before having dental work or surgery? Yes No
   If yes, why? _____

6. (Women) Are you pregnant? Yes No If yes, what is your due date? _____

7. (Women) Are you breast feeding? Yes No

8. (Women) Are you currently using birth control? Yes No If yes, what type? _____

9. Do you have any allergies to medications (including herbal products)? Yes No
   If yes, please list: _____

10. Do you have any special allergies (eg, latex)? Yes No
    If yes, please list: _____

PLEASE LIST THE **CURRENT MEDICATIONS** THAT YOU TAKE, INCLUDING OTC and HERBAL PRODUCTS:
(continue on the other side if necessary)

NAME OF MEDICATION	DOSAGE	TAKEN HOW OFTEN