

Solano Dermatology Associates
A Medical Corporation
2290 Sacramento Street Vallejo, CA 94590
Health Questionnaire

Patient Name: _____ Date: _____

Are you allergic to any medications? Please list: _____

Medications you are currently taking (include prescriptions, vitamins, and herbals):

Medication	Dose(mg)	How often (# / day)

Do you take Antibiotics prior to dental work? _____

Do you have now, or have you ever had diseases or conditions of:

- | | |
|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Yeast infection when taking Antibiotics |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Heart Valve problem |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Liver Disease |

Are you immune suppressed for any reason? _____

Do you have any other diseases or conditions? _____

List surgical procedures or hospitalizations you have had. _____

Skin History:

- | | |
|---|--------|
| Do you smoke? | Yes/No |
| Have you had an organ transplant? | Yes/No |
| Have you ever had a blistering sunburn? | Yes/No |
| Has anyone in your family ever had Melanoma? | Yes/No |
| Has anyone in your family ever had skin cancer other than melanoma? | Yes/No |
| Have you ever had a skin cancer other than melanoma? | Yes/No |
| Have you ever had melanoma? | Yes/No |

Has your skin condition been treated by a physician in the past? _____

Do you have problems with healing? _____

Do you develop keloids or hypertrophic scars after surgery? _____

Do you bleed easily? _____

Do you develop skin rashes in reaction to Medications? Food? Environment?

(Women) Are you pregnant? Yes No Due Date: __/__/__

What is your occupation? _____

Signed by Patient Date

Reviewed by Date

Rereviewed by Date