SOLANO DERMATOLOGY ASSOCIATES
A Medical Corporation
www.solanodermatology.com

Health Questionnaire

Date:_____

Patient Name: _____ **Date of Birth:**_____

Primary Care Physician:_____Referring Provider:_____Other:_____

Preferred Pharmacy:

Name:_____Street:_____City:_____Number:_____

Are you allergic to any medications? Please list:_____

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

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

Do you take Antibiotics prior to dental work?_____

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

□ High blood pressure	□ Heart murmur	□ Liver Disease	□ Glaucoma
□ Chest pain	□ Irregular heart beat	□ Diabetes	□ Heart Valve problem
□ Heart attack	□ Pacemaker	□ Kidney Trouble	□ Yeast infection when taking Antibiotics

Are you immune suppressed for any reason?_____

Do you have any other diseases or conditions?_____

List surgical procedures or hospitalizations you have had._____

Do you smoke? Yes/No
Type of tobacco use _____ Packs/day _____ Years smoked__ Yr quit __

Skin History:

Have you had an organ transplant? Yes/No
Have you ever had a blistering sunburn? 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?

Skin Cancer History:

Has anyone in your family ever had Melanoma? Yes/No
Family Member _____ Yr Diagnosed _____
Has anyone in your family ever had skin cancer other than melanoma? Yes/No
Have you ever had melanoma? Yes/No
Yr Diagnosed _____ Treatment _____
Have you ever had a skin cancer other than melanoma? Yes/No

(Women) Are you pregnant? Yes No Due Date: __/__/__
What is your occupation?_____
Race_____
Latino or Hispanic / Not Latino or Hispanic
Preferred Language_____

_____
Signed by Patient Date