HEALTH QUESTIONNAIRE

PLEASE DO NOT LEAVE ANY BLANKS

NAME:-_____ AGE:_____ REFERRING PHYSICIAN: _____

HEIGHT:_____ WEIGHT:_____ OCCUPATION:_____ MARITAL STATUS:_____

TOBACCO USE: Never____ Former_____ Current____ # ___ packs per day SMOKELESS TOBACCO (Chew): Yes/No

ALCOHOL USE: Never____ Occasional____ Daily____ # ____drinks per day RECREATIONAL DRUG USE: Yes/No

PETS IN THE HOME:_____ -CAT or DOG

In order to better understand your health and optimize your care, we ask that you complete this health questionnaire honestly and in its entirety.

Do you have or have you ever had any of the following conditions?	NO	If YES – please explain
Allergy to Latex, Band aids, Adhesive tape or antibiotic ointment	____	_____
Anxiety	____	_____
Arthritis	____	_____
Bee Sting Allergy	____	_____
Bleeding Disorder	____	_____
Depression	____	_____
Diabetes	____	_____
Fainting when having blood drawn	____	_____
History of Hepatitis C	____	_____
History of HIV or HIV risk factors	____	_____
History of motion sickness	____	_____
Have you had surgery under a local anesthetic (dental procedure etc.)	____	_____
Any problem getting or staying numb?	____	_____
Have you taken Codeine in the past	____	_____
Tolerated well? YES/NO If NO what side effects did you have? _____		
Heart Disease	____	_____
Do you have a PACEMAKER or DEFIBRILLATOR	____	_____
High Blood Pressure	____	_____
History of Repeated Skin Infections	____	_____
Liver Disorder	____	_____
Kidney Disorder	____	_____
Psychiatric Disorder	____	_____
Pulmonary Condition (Lung Disease)	____	_____
Seizure Disorder	____	_____
Shunts or plates from brain surgery	____	_____
Fever Blisters or Cold Sores	____	_____
Melanoma or "bad mole"	____	_____
Skin Cancer	____	_____
Eczema	____	_____
Keloids or thick scars	____	_____
Autoimmune Disease (ex. Lupus)	____	_____
Nail Fungus	____	_____

Other medical problems: _____

_____

Please list any major surgeries/hospitalizations you have had:_____

_____

_____

Did you experience any complications from anesthesia? NO / YES If Yes, please explain:_____

_____

Do you have a family history of Melanoma	_____	_____
Do you have a family history of skin cancer	_____	_____
Do you use sunscreen with zinc or titanium oxide	_____	_____
Do you use lipscreen or chapstick with sunscreen	_____	_____
Do you wear a hat or visor when in the sun	_____	Wide Brimmed or Baseball Cap
Do you wear sunglasses with UV protection	_____	_____
Have you ever used tanning beds	_____	Never / Past / Currently

PLEASE CIRCLE HOW YOUR SKIN RESPONDS TO THE SUN WITHOUT SUNSCREEN:

I – Always burns,never tans
II – Usually burns, tans with difficulty
III – Sometimes mild burn, gradually tans
IV – Rarely burns, tans easily (Caucasian or Mediterranean descent)
V – Very rarely burns, tans very easily (Middle Eastern descent)
VI – Never burns, tans very easily (African American descent)

Please circle any of the following that apply:

Wear contacts/glasses for Reading/Driving	Post nasal drip	History of blood clots
Fainting	Irregular heartbeats	Use oxygen at home
History of Jaundice	Acid Reflux	Hepatitis
Liver Disease	Neck pain or stiffness	Back -Limitation of movement/Arthritis
Vertigo	Tremors	Numbness, location _____
Dementia	Memory Loss	Bruise easily
Bleeding that is difficult to stop	Organ transplant	Do you take steroids

Please check any of the following supplements that you take:

Alfalfa___	Capsicum___	Celery___	Chamomile___
Chinese herbal teas___	Green tea___	Danshen___	Dong quai___
Fenugreek___	Feverfew___	Fish Oil___	Garlic___
Ginko___	Ginseng___	Horseradish___	Hauang qui___
Kava kava___	Licorice___	Passion Flower___	Red clover___
Multiple Vitamin___	Glucosamine___	Calcium___	B Vitamins___
Vitamin C___	Vitamin D___		

Please list any other supplements_____

_____

_____

Please list any allergies to medications you may have and the side effect: _____

_____

_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

MEDICATION AND DOSAGE	HOW OFTEN	MEDICATION AND DOSAGE	HOW OFTEN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you take a daily aspirin? YES / NO If yes what is the dosage:_____

Where is your skin lesion / growth / skin cancer located:_____

When did you first notice this condition:_____ Is it persistent or intermittent:_____

Does the growth bleed, cause you pain, or any other symptoms?_____

Family Physician:_____ Phone No.: _____

Pharmacy:_____ Location:_____Phone No.: _____

Completed By:_____

Relationship To Patient:_____

Date:_____