

PLACER DERMATOLOGY
& Skin Care Center
9285 Sierra College Blvd., Roseville, CA 95661
Phone (916) 784-3376 Fax (916) 784-9500

If possible, please fax, send,
or bring completed forms
with you to the appointment.

Patient Health Questionnaire

Patient Name: _____ Today's Date: _____
Last First M.I.

Reason for today's visit:

Did another physician refer you? Yes No Name of doctor: _____

How did you find out about Placer Dermatology? Please specify. Thank you.

- Family/Friend Compass Granite Bay View
 Phone Book Internet Style Magazine Other

Current Medications (including prescriptions, over-the counter medications, vitamins and herbals):

Do you have now or have you ever had diseases or conditions of: No

- | | |
|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Keloids (abnormal scarring) |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Liver Disease/Hepatitis _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Mood disorder _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Respiratory (Lung) Problems _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Other _____ |

Have you ever had local anesthesia? Yes No Any bad reactions? Yes No

Do you require antibiotics for Dental Work? Yes No

Do you have any of the following?

- artificial heart valve artificial joints pacemaker other metal implants

Do you develop skin rashes in reaction to: band-aids topical antibiotic _____

Do you have problems with healing? Yes No

Have you ever had any of the following skin cancers? No

- Basal Cell Cancer Location: _____ Treatment and date: _____
- Melanoma Location: _____ Treatment and date: _____
- Squamous Cell Cancer Location: _____ Treatment and date: _____
- Other _____ Location: _____ Treatment and date: _____

List any other Skin Disease you have or had: _____

Are you allergic to any medications? Yes No

If yes, list:

List any Major Surgical Procedures and Dates: _____

Family History of Skin Cancer? Yes No Type: _____

Family History of Asthma, Seasonal Allergies or Eczema? Yes No _____

Family History of any other skin disease? Yes No _____

Social History:

Do you drink alcohol? Yes No if yes drinks per day _____

Do you smoke? Yes No if yes how much? _____

What is your occupation? _____

Hobbies _____

Do you have or have you recently had any of the following? No

- | | | |
|---|---|--|
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Fever | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Headache | <input type="checkbox"/> Swollen Lymph Nodes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Joint Pains | <input type="checkbox"/> Visual Changes |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea or Vomiting | <input type="checkbox"/> Weight loss/gain over 10 pounds |
| <input type="checkbox"/> Other symptoms _____ | | |

Women only:

Are you pregnant? Yes No if yes, how many months? _____

Are you trying to conceive? Yes No

Are you breastfeeding? Yes No

The above information is correct to the best of my knowledge.

Signature of Patient (Parent or Legal Guardian if Minor):

_____ **Date:** _____

Print Name: _____