

# PLACER DERMATOLOGY

## & Skin Care Center

9285 Sierra College Blvd., Roseville, CA 95661

Phone (916) 784-3376 Fax (916) 784-9500

Please fax or send completed form prior to your appointment.

### Patient Health Questionnaire

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
*Last First M.I.*

Reason for today's visit:

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

How did you find out about Placer Dermatology?

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

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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

- Bleeding problems       Fever       Shortness of Breath
- Cough       Hair Loss       Skin Rash
- Depression       Headache       Swollen Lymph Nodes
- Dizziness       Joint Pains       Visual Changes
- Fatigue       Nausea or Vomiting       Weight loss/gain over 10 pounds
- 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:** \_\_\_\_\_