GEORGETOWN
DERMATOLOGISTS, P.C.

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HEALTH QUESTIONNAIRE

Today's Date: _____/_____/_____

Name: ______________________________ Age ______ Date of birth: _____/_____/_____

Reason for visit: ______________________________

Name of primary care physician: ______________________________

REVIEW OF SYMPTOMS: Please check any current symptoms you have

___Recent fevers/sweats
___Unexplained weight loss

___Change in vision

___Difficulty hearing
___Hay fever/allergies
___Trouble swallowing

___Chest pain/discomfort
___Palpitations
___Shortness of breath

___Cough/wheeze
___Coughing up blood

___Heartburn/reflux
___Nausea/vomiting/diarrhea
___Abdominal pain

___Painful/bloody urination
___Penile/vaginal discharge

___Muscle/joint pain
___Back pain

___Headache
___Anxiety/depression
___Increased stress

___Unexplained lumps
___Easy bruising/bleeding

___ Heat/cold intolerance
___ Increased thirst/appetite

SKIN CONDITIONS

___Eczema
___Psoriasis
___Other rashes
___New/changing moles
___Melanoma
___Other skin cancer
___Frequent sun exposure
___Scarring/keloids
___Hives

MEDICAL HISTORY: Check if you have any of the following

___Asthma/hay fever
___Coronary artery disease
___Heart attack
___Pacemaker
___Stomach ulcer

___Diabetes
___High blood pressure
___Stroke
___Colitis (UC, Crohn's, IBS)
___Depression/Anxiety

___Cancer (What type?)

___Thyroid disease
___Arthritis
___Herpes

___Hepatitis
___HIV/AIDS
___Tuberculosis
___Alcohol use/Smoking (circle)
___Sexually transmitted disease

FAMILY HISTORY: Indicate if family members have any of the following

	MOTHER	FATHER	SISTER/BROTHER
Eczema			
Psoriasis			
Melanoma			
Other skin cancer (SCC/BCC)			
Easy bleeding			

FEMALE PATIENTS:

Pregnant or nursing?	Yes	No
Regular menstrual periods?	Yes	No
Menopausal symptoms?	Yes	No
Birth control pill?	Yes	No
If yes, brand:		

MEDICATIONS: Please list prescription and non-prescription medicines, vitamins, herbs, supplements (*continue on back if needed)*

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DO YOU HAVE ALLERGIES TO MEDICINES? YES NO

If yes, please list: ______________________________

Doctor has reviewed medical information above with patient

PATIENT/GUARDIAN SIGNATURE: ______________________________

DOCTOR SIGNATURE: ______________________________