



## PATIENT HEALTH QUESTIONNAIRE

*All information collected in this questionnaire is strictly confidential and will become part of your medical record.  
Please bring this completed form with you to your consultation.*

### PATIENT DATA

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Gender: ☐ Female ☐ Male

Marital Status: \_\_\_\_\_

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

Race:

- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other

### PAST MEDICAL HISTORY

Have you had any of the following conditions?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> anxiety                                   | <input type="checkbox"/> coronary artery disease | <input type="checkbox"/> hyperthyroidism     |
| <input type="checkbox"/> arthritis                                 | <input type="checkbox"/> depression              | <input type="checkbox"/> hypothyroidism      |
| <input type="checkbox"/> artificial joints                         | <input type="checkbox"/> diabetes                | <input type="checkbox"/> leukemia            |
| <input type="checkbox"/> asthma                                    | <input type="checkbox"/> end stage renal disease | <input type="checkbox"/> lung cancer         |
| <input type="checkbox"/> atrial fibrillation (irregular heartbeat) | <input type="checkbox"/> GERD                    | <input type="checkbox"/> lymphoma            |
| <input type="checkbox"/> BPH                                       | <input type="checkbox"/> hearing loss            | <input type="checkbox"/> prostate cancer     |
| <input type="checkbox"/> bone marrow transplantation               | <input type="checkbox"/> hepatitis               | <input type="checkbox"/> radiation treatment |
| <input type="checkbox"/> breast cancer                             | <input type="checkbox"/> hypertension            | <input type="checkbox"/> seizures            |
| <input type="checkbox"/> colon cancer                              | <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> stroke              |
| <input type="checkbox"/> COPD                                      | <input type="checkbox"/> hypercholesterolemia    |  |

Other: \_\_\_\_\_

### PAST SURGERIES

Have you had any previous surgeries? If so, what and when?

\_\_\_\_\_

### SKIN DISEASE HISTORY

Have you had any of the following?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> acne                   | <input type="checkbox"/> dry skin               | <input type="checkbox"/> poison ivy                |
| <input type="checkbox"/> actinic keratoses      | <input type="checkbox"/> eczema                 | <input type="checkbox"/> precancerous moles        |
| <input type="checkbox"/> asthma                 | <input type="checkbox"/> flaking or itchy scalp | <input type="checkbox"/> psoriasis                 |
| <input type="checkbox"/> basal cell skin cancer | <input type="checkbox"/> hay fever/allergies    | <input type="checkbox"/> squamous cell skin cancer |
| <input type="checkbox"/> blistering sunburns    | <input type="checkbox"/> melanoma               |  |

Other: \_\_\_\_\_

Do you wear sunscreen? ☐ Yes ☐ No

If yes, what SPF? \_\_\_\_\_

Do you tan in a tanning salon? ☐ Yes ☐ No

## PATIENT HEALTH QUESTIONNAIRE (*continued*)

### FAMILY HISTORY

Do you have a family history of melanoma? ☐ Yes ☐ No If yes, which relative/s? \_\_\_\_\_

### MEDICATIONS

Are you currently on prescription medication? ☐ Yes ☐ No If yes, please list: \_\_\_\_\_

Do you take over-the-counter drugs, vitamins, supplements, or use inhalers? ☐ Yes ☐ No

If yes, please list: \_\_\_\_\_

### ALLERGIES

Do you have any allergies? ☐ Yes ☐ No If yes, what? \_\_\_\_\_

### SOCIAL HISTORY

Please check all that apply:

☐ Currently smokes ☐ Has smoked in the past ☐ Never smoked ☐ Drug use ☐ Alcohol use

Frequency: \_\_\_\_\_

Occupation + Workplace: \_\_\_\_\_

### REVIEW OF SYSTEMS

Do you have any of the following?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> headaches       | <input type="checkbox"/> dizziness                | <input type="checkbox"/> abdominal pain   |
| <input type="checkbox"/> joint aches     | <input type="checkbox"/> muscle aches             | <input type="checkbox"/> depression       |
| <input type="checkbox"/> fever or chills | <input type="checkbox"/> menstrual irregularities | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> cough           | <input type="checkbox"/> sore throat              | <input type="checkbox"/> rash             |

### ALERTS

Do you have any of the following?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> pacemaker                               | <input type="checkbox"/> difficulty stopping bleeding            | <input type="checkbox"/> pregnancy or planning a pregnancy               |
| <input type="checkbox"/> defibrillator                           | <input type="checkbox"/> blood thinners                          | <input type="checkbox"/> breastfeeding                                   |
| <input type="checkbox"/> artificial joints (within past 2 years) | <input type="checkbox"/> allergy to adhesive                     | <input type="checkbox"/> rapid heart beat with epinephrine               |
| <input type="checkbox"/> artificial heart valve                  | <input type="checkbox"/> allergy to topical antibiotic ointments | <input type="checkbox"/> yeast infection with antibiotics                |
| <input type="checkbox"/> premedication prior to procedures       | <input type="checkbox"/> allergy to lidocaine                    | <input type="checkbox"/> problems with scarring (hypertrophic or keloid) |

### PATIENT SIGNATURE

Signature: \_\_\_\_\_ Date: \_\_\_\_\_