Laborde Dermatology Medical History Questionnaire

Patient Name: ______________________________ **DOB:** __________________

Medications you are currently taking/using:
Oral: ____
Topical: ____

Allergies: ____

What is the primary reason for your visit today?

____

Have you or do you currently have: (please check all that apply)

Skin cancer	Glaucoma	Joint disease
type _______________	Heart valve replacement	Immune System problems
location ____________	History of keloids	History of cancer (type) ______
Lung problems	Kidney disease	History of stroke
Asthma	Neurological disorder	Sinus problems
History of cold sores	Low blood sugar	Arthritis
Blood disorder	Thyroid disease	Pacemaker
Anemia	High blood pressure	History of Accutane use
Hepatitis (type)________	Diabetes	Ulcers / Gastrointestinal disease

Other: ____

Have you had any surgical procedures in the past five years? □ Yes □ No
If so, please describe: ____

Is there any family history of: (if yes, please describe family relation)

□Yes □No Basal cell carcinoma relation______________________________
□Yes □No Squamous cell carcinoma relation______________________________
□Yes □No Melanoma relation______________________________
□Yes □No Vitiligo relation______________________________
□Yes □No Psoriasis relation______________________________
□Yes □No Other Skin Disease relation______________________________

Female Patients: (please check)

Contemplating pregnancy	Breastfeeding
Pregnant	Irregular Menses

All patients:
Do you smoke tobacco? If so, how often: ____
Do you drink alcoholic beverages? If so, how often: ______________________________
Do you have a history of blistering sunburns or excessive sun exposure? __________________
Do you have a history of tanning bed use? When and how often? ____________________
Is there any other condition concerning your health that the doctor should be told? If so, please describe. ____

Signature: __________________________________ **Date:**___________

Medical History Questionnaire, Continued

How did you hear about us?

□ My physician (full name): ____
□ Family member (relative/name):____
□ Friend (name): ____
□ Radio Station :____
□ Yellow Pages
□ Insurance company (name) ____
□ Salon / Spa (name): ____
□ Article or advertisement in: ____
□ Google
□ Yahoo
□ Other, please specify:____

If personally referred, whom may we thank for the referral? _______________________

Areas you would like to discuss or receive more information (please check all that apply):

□ Freckles / Brown Spots
□ Dark Circles
□ Sun Damage
□ Droopy Eyelids
□ Large Pores
□ Microdermabrasion
□ Wrinkles
□ Acne
□ Acne Scarring
□ Laser Hair Removal
□ Laser Treatments

□ Removing Facial Blood Vessels
□ Leg Spider Veins
□ Excessive Hair Growth
□ Excessive Sweating (palms, soles, underarms)
□ Frown Lines
□ Chemical / Antioxidant Peels
□ Botox
□ Dermal Fillers (Juvederm, Restylane, Collagen)
□ Correction of low set eyebrows

□ Mouth (perioral) lines
□ Lower Face Folds
□ Lip Augmentation
□ Facial Redness
□ Rosacea
□ Skin Care Advice
□ Skin Care Products

□ Other, please specify: ____

Have you had any cosmetic surgery or procedures in the past five years?

□ **Yes** □ **No**

If so, please describe: ____

Signature ______________________________ **Date** _____________

Print Name ____________________________