

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 type _____ location _____	Glaucoma Heart valve replacement History of keloids Kidney disease Neurological disorder Low blood sugar Thyroid disease High blood pressure Diabetes	Joint disease Immune System problems History of cancer (type) _____ History of stroke Sinus problems Arthritis Pacemaker History of Accutane use Ulcers / Gastrointestinal disease
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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)

<input type="checkbox"/> Yes <input type="checkbox"/> No	Basal cell carcinoma	relation _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Squamous cell carcinoma	relation _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Melanoma	relation _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Vitiligo	relation _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Psoriasis	relation _____
<input type="checkbox"/> Yes <input type="checkbox"/> 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):

- | | | |
|---|--|---|
| <input type="checkbox"/> Freckles / Brown Spots | <input type="checkbox"/> Removing Facial Blood Vessels | <input type="checkbox"/> Mouth (perioral) lines |
| <input type="checkbox"/> Dark Circles | <input type="checkbox"/> Leg Spider Veins | <input type="checkbox"/> Lower Face Folds |
| <input type="checkbox"/> Sun Damage | <input type="checkbox"/> Excessive Hair Growth | <input type="checkbox"/> Lip Augmentation |
| <input type="checkbox"/> Droopy Eyelids | <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Facial Redness |
| <input type="checkbox"/> Large Pores | <input type="checkbox"/> (palms, soles, underarms) | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Frown Lines | <input type="checkbox"/> Skin Care Advice |
| <input type="checkbox"/> Wrinkles | <input type="checkbox"/> Chemical / Antioxidant Peels | <input type="checkbox"/> Skin Care Products |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Botox | |
| <input type="checkbox"/> Acne Scarring | <input type="checkbox"/> Dermal Fillers | |
| <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> (Juvederm, Restylane, Collagen) | |
| <input type="checkbox"/> Laser Treatments | <input type="checkbox"/> Correction of low set eyebrows | |
| <input type="checkbox"/> 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 _____