

Kinnelon Dermatology Associates Health History Questionnaire

Patient Name: _____ Date of Birth _____

Have you had any of the following conditions in the past?	Check if YES	Are you <u>currently</u> experiencing any of the following conditions?	Check if YES	Have you had any of the following Surgeries in the past?	Check if YES
Acne		Acne		Appendectomy	
Actinic Keratosis		Anemia		Carpel Tunnel Release	
AIDS		Asthma		Cataracts	
Anemia		Bleeding/ Clotting disorder		Cancer Treatments	
Anxiety		Bloody nose		Endoscopy	
Asthma		Changes in skin lesion		Heart Bypass Surgery	
Atrial Flutter/ Fibrillation		Chest pains		Heart Valve Replacement	
Abnormal Moles		Discharge from your eyes		Hernia Repair	
Basal Cell Carcinoma		Dry skin		Joint Replacement	
Breast lumps or masses		Dryness in the nose		Pacemaker	
Cancer		Dryness in your eyes		Removal of Gallbladder	
Cold Sores		Enlarged lymph nodes		Tonsillectomy	
Colitis		Excessive bleeding		Other:	
Depression		Fatigue		Personal Habits	
Dermatitis		Fever		Are you taking Coumadin?	
Diabetes		Hair loss		Are you taking aspirin?	
Eczema		Heart arrhythmia		Do you drink alcohol?	
Glaucoma		Heart palpitations		Do you use drugs	
Heart Disease		Hives		Do you have tattoos	
Heart Murmur		Inflamed skin		Do you have piercings?	
Hepatitis		Itching of your eyes		Do you smoke?	
Herpes Simplex		Itchy skin		Do you use sunscreen?	
Hirsutism		Keloid		Have you had sunburn blisters?	
HIV Infection		Moles that have changed		Have you ever had sunburn?	
Kidney Disease		Numbness/ tingling		Do you use a tanning bed?	
Hypertension		Oily skin		Are you pregnant?	
Lupus		Poor healing of wounds		Are you nursing?	
Melanoma		Skin bruises easily		Do you plan on becoming pregnant?	
Mitral Valve Prolapse		Sun sensitivity and swelling		Family Medical History	
Psoriasis		Sweats		Allergies (Seasonal)	
Prostate issues		Vericose Veins		Atypical Moles	
Sarcoid		Weight Gain		Basal Cell Carcinoma	
Skin Cancer		Weight Loss		Diabetes	
Seizure/Epilepsy		Wheezing		Eczema	
Squamous Cell Carcinoma		Other: (please list)		Lupus	
Stroke/ TIA				Melanoma	
T-Cell Lymphoma				Psoriasis	
Thyroid Disease				Sarcoid	
				Skin Cancer	

*Medication Allergies: _____

*Current Medications: _____
