Texas Tech Physicians
DERMATOLOGY

Name:_____
MRN:_____
DOB:_____

Patient Medical History Questionnaire

Date:_____ Daytime Phone Number:_____

Reason for visit: _____ Duration:_____ days/months/years

Areas Involed:_____ Previous treating Physicians:_____

Surgical History:_____

Medication Allergies:_____

Current Medications:_____

Preferred Pharmacy:_____

PLEASE ANSWER ALL QUESTIONS BY CHECKING ANY BOXES THAT APPLY:

- ☐ Eczema
- ☐ Skin Cancer _____(type)
- ☐ Other Cancer:_____(type)
- ☐ Family History of Melanoma
- ☐ Keloids or Excessive Scarring
- ☐ Lupus Erythematosus
- ☐ HIV or Aids
- ☐ Chronic Pain
- ☐ Bleeding Tendency
- ☐ Anemia (low blood count)
- ☐ Mental Health Problems
- ☐ Asthma
- ☐ Lung Disease
- ☐ Heart Disease, Murmurs, or Rheumatic Fever
- ☐ Diabetes
- ☐ Stomach or Peptic Ulcers
- ☐ Chronic Kidney Disease
- ☐ Bone Disease
- ☐ Hay Fever
- ☐ Tuberculosis
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Thyroid Disease
- ☐ Hepatitis or Liver Disease _____(type)
- ☐ Arthritis
- ☐ Seizures or Epilepsy

Women:

- ☐ Pregnant Due Date:_____
- ☐ Breastfeeding

<u>Educational History</u>
Highest Level of Education:_____
Preferred Language:_____
Preferred method of learning: ___Oral ___Read___Video

<u>Social History</u>
Occupation:_____
Do you drink Alcohol? __Y __N (____Drinks per day)
Do you smoke? ___Y __N (_____Packs per day)

Patient Signature:_____ Date:_____

I have reviewed and discussed with the patient the information on this form.

Physician Signature:_____