Rebecca T. Satoskar, MD
Integrated Dermatology of Fairfax

HEALTH QUESTIONNAIRE

Date: _____

Name: _____ **Age:** _____ **Date of Birth:** _____

Referred By: _____

Primary Care Physician: Dr._____ **Phone:** _____

Reason for Visit (One or Two Main Problems to Address Today): _____

_____

Duration of Problem: _____

Treatment: _____

Aggravating factors: _____

Current Medications (please include OTC, herbs, vitamins, supplements): _____

_____

_____

Allergies to Medication: ☐None ☐ _____

Other Allergies: ☐None ☐Latex ☐Bandages/Adhesive

☐Topical Antibiotic (Neosporin or other) _____

Have you ever had any bad reaction to local anesthesia? ☐No ☐Yes ☐Never had anesthesia

FOR WOMEN ONLY:

Are you currently pregnant, trying to become pregnant, or are you nursing? _____

Are you on a contraceptive, if so what form? _____

SKIN CONDITIONS:

Have you ever had skin cancer? ☐No ☐Yes

If Yes, ☐Basal Cell Cancer ☐Squamous Cell Cancer ☐Melanoma

Where? _____**When?** _____

Treatment? _____

Has anyone if your family ever had skin cancer? ☐No ☐Yes

If Yes, ☐Basal Cell Cancer ☐Squamous Cell Cancer ☐Melanoma

Who? _____

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Do you have a history of any skin problems or diseases? ☐No ☐Yes

If Yes, ☐Psoriasis ☐Eczema ☐Keloid ☐Other _____

SUN EXPOSURE:

When you are exposed to the sun do you:

- ☐ always burn
- ☐ usually burn, tan minimally
- ☐ sometimes mild burn, tan uniformly
- ☐ rarely burn, always tan well
- ☐ very rarely burn, tan very easily
- ☐ never burn, tan very easily

Where did you grow up? _____

Did you have:

- ☐ sunburns every summer in childhood
- ☐ at least one blistering sunburn, how many _____
- ☐ ever use a tanning bed, how many times/how often _____
- ☐ regular sunscreen use, SPF _____

PAST SURGERIES (Type and Date):_____

_____

_____

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS:

Allergic/Immunologic: ☐Normal ☐Seasonal allergies ☐Immunosuppression ☐Autoimmune problem

Constitutional: ☐Normal ☐Weight loss/weight gain ☐Fever/Nightsweats ☐Fainting

Cancer: Type _____

Cardiovascular: ☐Normal ☐Artificial Heart Valve ☐Pacemaker ☐Implanted Defibrillator ☐Irregular Heartbeat ☐Chest Pain/Heart attack ☐Mitral Valve Prolapse ☐Other _____

Ears/Eyes/Nose: ☐Normal ☐Glaucoma ☐Glasses/Contacts ☐Other _____

Endocrine: ☐Normal ☐Diabetes ☐Thyroid Disease ☐Other _____

Gastrointestinal: ☐Normal ☐Reflux ☐Liver Problem ☐Nausea ☐Diarrhea ☐Other _____

Genital/Urinary: ☐Normal ☐Enlarged Prostate ☐Prostate Cancer

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Hematologic: ☐Normal ☐Anemia ☐Bleeding Problems ☐Other _____

Infections: ☐Normal ☐HIV ☐Hepatitis ☐Tuberculosis/+PPD Skin Test

☐Other _____

Musculoskeletal: ☐Normal ☐Arthritis ☐Artificial Joint ☐Other _____

Neurological: ☐Normal ☐Stroke ☐Seizures/Epilepsy ☐Multiple Sclerosis

☐Other _____

Respiratory: ☐Normal ☐Asthma ☐Emphysema ☐Other _____

Psychiatric: ☐Normal ☐Depression ☐Anxiety Attacks ☐Other _____

Others: ☐Kidney Problems ☐Cold Sores ☐Varicose Veins

☐Require Antibiotics Prior to Dentistry

Any other medical problems: _____

FAMILY HISTORY: ☐Eczema ☐Psoriasis ☐Other _____

SOCIAL HISTORY:

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow/Widower

Occupation: _____

Smoking: ☐No ☐Former ☐Yes, packs/day _____

Alcohol: ☐No ☐Yes, how much/often _____

By signing, I am acknowledging that I have disclosed all of my health information known to me at this time, and all of my other personal information is accurate. I understand that it is my obligation and responsibility to notify Integrated Dermatology of Fairfax of any changes in my medical information during the course of my medical treatment.

- **SIGNATURE**_____ **Date** _____

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