DERMATOLOGY

PATIENT HEALTH QUESTIONNAIRE

All information collected in this questionnaire is strictly confidential and will become part of your medical record.

PATIENT DATA

Last Name: _____ First Name: _____ Middle Initial: _____

Gender: ☐ Female ☐ Male

Marital Status: _____

Ethnicity:

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

Race:

☐ White
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ Other

PAST MEDICAL HISTORY

Have you had any of the following conditions?

☐ anxiety
☐ arthritis
☐ artificial joints
☐ asthma
☐ atrial fibrillation (irregular heartbeat)
☐ BPH
☐ bone marrow transplantation
☐ breast cancer
☐ colon cancer
☐ COPD
☐ coronary artery disease
☐ depression
☐ diabetes
☐ end stage renal disease
☐ GERD
☐ hearing loss
☐ hepatitis
☐ hypertension
☐ HIV/AIDS
☐ hypercholesterolemia
☐ hyperthyroidism
☐ hypothyroidism
☐ leukemia
☐ lung cancer
☐ lymphoma
☐ prostate cancer
☐ radiation treatment
☐ seizures
☐ stroke

Other: _____

PAST SURGERIES

Have you had any previous surgeries? If so, what and when? _____

SKIN DISEASE HISTORY

Have you had any of the following?

☐ acne
☐ actinic keratoses
☐ asthma
☐ basal cell skin cancer
☐ blistering sunburns
☐ dry skin
☐ eczema
☐ flaking or itchy scalp
☐ hay fever/allergies
☐ melanoma
☐ poison ivy
☐ precancerous moles
☐ psoriasis
☐ squamous cell skin cancer

Other: _____

Do you wear sunscreen? ☐ Yes ☐ No

If yes, what SPF? _____

Do you tan in a tanning salon? ☐ Yes ☐ No

Anthony, Van Vreede, MD
board-certified dermatologist

T: 248.617.9020 · F: 248.617.9019 · www.vdermatologyandspa.com
12660 Ten Mile Road, Suite 2A · South Lyon, MI 48178 ·

PATIENT HEALTH QUESTIONNAIRE *(continued)*

FAMILY HISTORY

Do you have a family history of melanoma? ☐ Yes ☐ No If yes, which relative/s? _____

MEDICATIONS

Are you currently on prescription medication? ☐ Yes ☐ No If yes, please list: _____

_____

Do you take over-the-counter drugs, vitamins, supplements, or use inhalers? ☐ Yes ☐ No

If yes, please list: _____

_____

ALLERGIES

Do you have any allergies? ☐ Yes ☐ No If yes, what? _____

SOCIAL HISTORY

Please check all that apply:

☐ Currently smokes ☐ Has smoked in the past ☐ Drug use ☐ Alcohol use

Other: _____

Occupation + Workplace: _____

REVIEW OF SYSTEMS

Do you have any of the following?

- ☐ headaches
- ☐ joint aches
- ☐ fever or chills
- ☐ cough
- ☐ dizziness
- ☐ muscle aches
- ☐ menstrual irregularities
- ☐ sore throat
- ☐ abdominal pain
- ☐ depression
- ☐ thyroid problems
- ☐ rash

ALERTS

Do you have any of the following?

- ☐ pacemaker
- ☐ defibrillator
- ☐ artificial joints (within past 2 years)
- ☐ artificial heart valve
- ☐ premedication prior to procedures
- ☐ difficulty stopping bleeding
- ☐ blood thinners
- ☐ allergy to adhesive
- ☐ allergy to topical antibiotic ointments
- ☐ allergy to lidocaine
- ☐ pregnancy or planning a pregnancy
- ☐ breastfeeding
- ☐ rapid heart beat with epinephrine
- ☐ yeast infection with antibiotics
- ☐ problems with scarring (hypertrophic or keloid)

PATIENT SIGNATURE

Signature: _____ Date: _____

Anthony, Van Vreede, MD
board-certified dermatologist

T: 248.617.9020 · F: 248.617.9019 · www.vdermatologyandspa.com
12660 Ten Mile Road, Suite 2A · South Lyon, MI 48178 ·