

Idaho Dermatologic Surgery and Laser Center

Teri J. Cottingham, M.D. • Ashley Cafferty, PA-C

Medical History Questionnaire (please print)

Name: _____

Occupation: _____

Birthdate: _____ Age: _____

Referring Physician: _____

- What is your skin problem? (rash, growths, warts, etc.) **YES NO**

- When did you first notice this problem?

- Has a doctor given you anything for this skin condition? ..
If yes, please give names of **EVERYTHING** used:

- Have you put anything else on the skin yourself?
If yes, please give names of **EVERYTHING** used:

- Have you had any other skin problems?
If yes, please list:

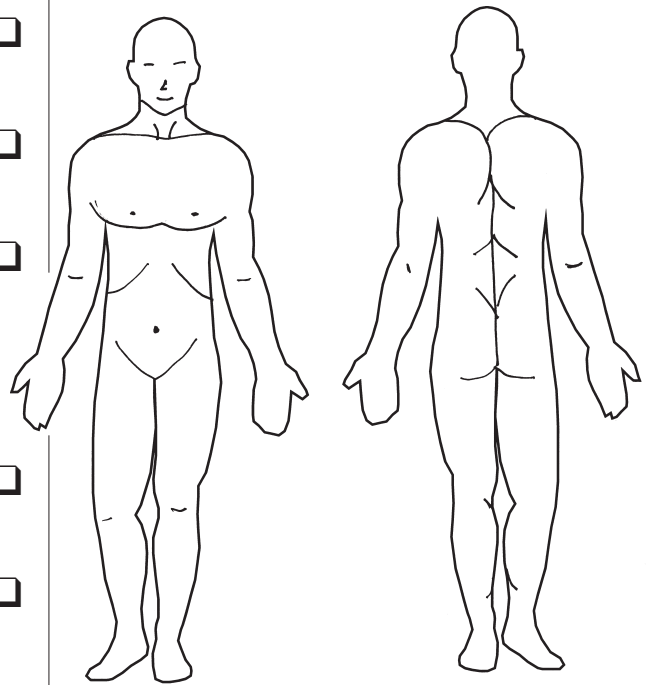
- What have you treated these problems with?

- Does anyone in your family have skin problems or rashes?

- Does anything **TOUCHING** your skin (jewelry, Poison Oak, etc.) cause a rash or allergy?
If yes, please list:

- When exposed to the sun, do you:
 Always burn Sometimes burn Rarely burn Always tan

• Please **DRAW** on this chart where your present skin problem or rash is, by marking X's on the figure:



HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- | | |
|--|--|
| <ul style="list-style-type: none"> • Heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No • Angina or heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No • Heart rhythm abnormality <input type="checkbox"/> Yes <input type="checkbox"/> No • Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No • Mitral valve prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No • Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No • Artificial heart valve(s) <input type="checkbox"/> Yes <input type="checkbox"/> No • Artificial joint(s) (e.g. hip, knee) <input type="checkbox"/> Yes <input type="checkbox"/> No • Antibiotics before undergoing dental or surgical procedures <input type="checkbox"/> Yes <input type="checkbox"/> No • High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No • Lung disease <input type="checkbox"/> Yes <input type="checkbox"/> No • Breathing difficulty <input type="checkbox"/> Yes <input type="checkbox"/> No • Ulcers (stomach) <input type="checkbox"/> Yes <input type="checkbox"/> No • Kidney disease <input type="checkbox"/> Yes <input type="checkbox"/> No • Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No • Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | <ul style="list-style-type: none"> • Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No • Hepatitis or yellow jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No • Blood transfusions <input type="checkbox"/> Yes <input type="checkbox"/> No • AIDS or HIV positive <input type="checkbox"/> Yes <input type="checkbox"/> No • Thyroid disease <input type="checkbox"/> Yes <input type="checkbox"/> No • Emotional disorder <input type="checkbox"/> Yes <input type="checkbox"/> No • Fainting spells or dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No • Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No • Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No • Lupus/Dermatomyositis <input type="checkbox"/> Yes <input type="checkbox"/> No • Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No • Bleeding disorder or tendency <input type="checkbox"/> Yes <input type="checkbox"/> No • Excessive scarring or keloids <input type="checkbox"/> Yes <input type="checkbox"/> No • Problems with healing <input type="checkbox"/> Yes <input type="checkbox"/> No • Surgical wound infection <input type="checkbox"/> Yes <input type="checkbox"/> No • Cold sores or fever blisters <input type="checkbox"/> Yes <input type="checkbox"/> No • X-ray treatment to your skin <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|

OVER PLEASE

.....
HAVE YOU OR ANY OF YOUR FAMILY HAD?

- | | YOU | | FAMILY | | |
|---------------------|------------------------------|-----------------------------|------------------------------|-----------------------------|---------------------|
| • Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| • Hay Fever..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| • Allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| • Eczema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| • Hives | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| • Hemophilia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| • Skin cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, whom: _____ |
| • Melanoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, whom: _____ |
-

- Are you pregnant?..... N/A Yes No
If yes, estimated due date: _____
 - Are you planning on becoming pregnant in the near future? N/A Yes No
 - Are you breast-feeding?..... N/A Yes No
 - Do you use birth control? N/A Yes No
If yes, which method: _____
-

- Do you smoke? Yes No If yes, how much? _____ For how long? _____
If a past smoker, was a smoking cessation / aid used to stop? Yes No
If yes, what kind: _____
 - Do you drink alcohol?..... Yes No
If yes, how much: _____
-

- Please list all medical problems / illnesses:

- Please list all surgeries:

- Are you allergic to any medications Yes No
If so, please list: _____
- Have you experienced any adverse reaction to local anesthetic? Yes No
If yes, please describe: _____

- Please list all medications:
 - Prescription medications, both oral and topical
 - "Over-the-counter" medications, including herbal preparations
 - Those taken regularly and those taken on an as needed basis_____

Signature: _____ Date: _____