

# English Dermatology Centers Medical History Questionnaire

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Other than English Dermatology, list any Physicians have you seen for dermatology concerns? \_\_\_\_\_

What are you being seen for today? (Due to limited time between appointments, we can only address ONE concern per office visit) \_\_\_\_\_

List all prescription medications and supplements you are currently taking and include the dose and reason for each:

\_\_\_\_\_  
\_\_\_\_\_

List any ALLERGIES or if you have an allergy to LATEX:

\_\_\_\_\_  
\_\_\_\_\_

List any surgeries you have had including the year:

\_\_\_\_\_  
\_\_\_\_\_

Describe any hospitalization/illness not listed above:

\_\_\_\_\_  
\_\_\_\_\_

Do you have a family history of skin cancer? (name the type of cancer and relationship to you):

\_\_\_\_\_

## **Have you had any of the following:**

Basal Cell Carcinoma (BCC)

Malignant Melanoma (MM)

Rheumatic Fever

Mental Illness

Arthritis

HIV/AIDS

Squamous Cell Carcinoma (SCC)

Actinic Keratosis (Precancer)

Hepatitis

Blood Clots

Gout