Pacific Dermatology INSTITUTE

Pacific Plastic Surgery and LASER CENTER

MEDICAL QUESTIONNAIRE PAGE 1

Date:_____

Name: Last, First, MI: _____ Date of Birth:_____

If minor, responsible parent name:_____

PAST MEDICAL HISTORY: (please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostetic Hyperplasia
- ☐ Cerebrovascular Accident
- ☐ COPD
- ☐ Coronary Arteriosclerosis
- ☐ Depressive Disorder
- ☐ Diabetes Mellitus
- ☐ Disease Caused by Covid-19
- ☐ Elevated Blood Pressure
- ☐ End State Renal Disease
- ☐ Epilepsy
- ☐ GERD
- ☐ H/O Hypertension
- ☐ Hearing Loss
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory Liver Disease
- ☐ Leukemia
- ☐ Malignant Lymphoma
- ☐ Malignant Tumor of Breast
- ☐ Malignant Tumor of Colon
- ☐ Malignant Tumor of Lung
- ☐ Malignant Tumor of Prostate
- ☐ Radiation Therapy
- ☐ Transplantion of Bone Marrow

Other: _____

PAST SURGICAL HISTORY: (please check all that apply)

- ☐ Abdominoperineal Resection
- ☐ Bilateral Replacement of Knee Joints
- ☐ Biopsy of Breast
- ☐ Biopsy of Prostate
- ☐ Coronary Artery Bypass Graft
- ☐ Entire Transplanted Kidney
- ☐ Excision of Basal Cell Carcinoma
- ☐ Excision of Melanoma
- ☐ Excision of Squamous Cell Carcinoma
- ☐ Colostomy
- ☐ Tubal Ligation
- ☐ Appendectomy
- ☐ Bilateral Mastectomy
- ☐ Cholecystectomy
- ☐ Colectomy
- ☐ Liver Excision
- ☐ Percutaneous Transluminal Coronary Angioplasty
- ☐ Tissue Graft Heart Valve Replacement
- ☐ Total Cystectomy
- ☐ Transurethral Prostatectomy
- ☐ Hysterectomy
- ☐ Kidney Biopsy
- ☐ Low Anterior Resection of Rectum
- ☐ Lumpectomy of Right Breast
- ☐ Lumpectomy of Left Breast
- ☐ Mastectomy of Right Breast
- ☐ Mastectomy of Left Breast
- ☐ Mechanical Heart Valve Replacement
- ☐ Oophorectomy
- ☐ Pancreatectomy
- ☐ Total NephrectomyProcedure
- ☐ Prostatectomy
- ☐ Percutaneous Extraction of Kidney Stone with Fragentation
- ☐ Portosystemic Shunt Operation
- ☐ Prosthetic Arthroplasty of Bilateral Hips
- ☐ Splenectomy
- ☐ Surgical Biopsy of Skin
- ☐ Total Nephrectomy
- ☐ Total Orchidectomy
- ☐ Total Replacement of (Left, Right) Hip Joint
- ☐ Total Replacement of (Left, Right) Knee
- ☐ Transplant of Heart
- ☐ Transplant of Liver

☐ NONE

Other: _____

SKIN DISEASE HISTORY

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asteatosis Cutis
- ☐ Basal Cell Carcinoma of Skin
- ☐ Contact Dermatitis Poison Ivy
- ☐ Dysplastic Nevus of Skin
- ☐ Eczema
- ☐ Asthma
- ☐ Hay Fever / Allergies
- ☐ Malignant Melanoma
- ☐ Pruritus of Scalp
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- ☐ Sunburn of Second Degree
- ☐ NONE

Other: _____

Do you wear sunscreen? ☐ Yes ☐ No

If yes, what SPF? _____

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

Do you have a family history of Melanoma? ☐ Yes ☐ No

If yes, which relative(s)? _____

Medications: (Please list all current medications) _____

Medications Allergies:

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SOCIAL HISTORY: (please check all that apply)

Cigarette Smoking:

- ☐ Currently Smokes
- ☐ Has smoked in the past
- ☐ Never Smoked
- ☐ Former Smoker

Alcohol Use:

- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1-2 Drinks per day
- ☐ 3 or more drinks per day

Other: _____

Family Medical History (Only first degree relatives)

_____

_____

Preferred Pharmacy Name: _____

Pharmacy Phone #: _____

Pharmacy City or Zip code: _____

REVIEW OF SYSTEMS: Are you currently experiencing any of the following?

Hay Fever	☐ Yes	☐ No	Abdominal Pain	☐ Yes	☐ No
Probelms with Bleeding	☐ Yes	☐ No	Bloody Stool	☐ Yes	☐ No
Problems with Healing	☐ Yes	☐ No	Bloody Urine	☐ Yes	☐ No
Keloid	☐ Yes	☐ No	Joint Aches	☐ Yes	☐ No
Rash	☐ Yes	☐ No	Muscle Weakness	☐ Yes	☐ No
Immunosuppression	☐ Yes	☐ No	Neck Stiffness	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Fever or Chills	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Night Sweats	☐ Yes	☐ No	Cough	☐ Yes	☐ No
Unintentional Weight Loss	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No	Wheezing	☐ Yes	☐ No
Sore Throat	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Blurry Vision	☐ Yes	☐ No	Depression	☐ Yes	☐ No

Other Symptoms: _____

ALERTS: (please check all that apply)

- ☐ Allergy to Adhesive
- ☐ Allergy to Lidocaine
- ☐ Allergy to Topical Antibiotics
- ☐ Require Antibiotics prior to a surgical procedure
- ☐ Rapid heartbeat with epinephrine
- ☐ Pregnant or Trying to become Pregnant
- ☐ Dementia
- ☐ HIV+
- ☐ Artificial Heart Valve
- ☐ Artificial Joint Replacement
- ☐ Blood Thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Alzheimer's
- ☐ Hepatitis C

_____ _____ _____

(Signature of Patient or Responsible Party) Printed Name Date