Pacific Dermatology INSTITUTE

Pacific Plastic Surgery and LASER CENTER

Date: _____

MEDICAL QUESTIONNAIRE

Name: Last, First, MI: _____ Nickname: _____ Gender: _____

If minor, responsible parent name: _____ Date of Birth: _____

1. Last skin exam: _____
   Do you sunbathe? ◯ Yes ◯ No
   Do you use tanning beds? ◯ Yes ◯ No
   Pacemaker or defibrillator? ◯ Yes ◯ No
2. Do you have sensitivity to lidocaine or epinephrine
3. Do you bleed easily? ◯ Yes ◯ No
4. Do you have any known allergies or allergic to any medications? ◯ Yes ◯ No

_____

SKIN HISTORY

5. Please mark the skin conditions that you or your family / blood relatives have presently or have had in the past

Condition	Self	Family	Relation
Skin Cancer			
Melonoma			
Acne / Accutane			
Keloids / Scars			
Eczema / Rashes			

Condition	Self	Family	Relation
Psoriasis			
Difficulty with wound healing			
Difficulty with skin infections			
Hives			
Other Skin Conditions			

MEDICAL CONDITIONS

5. Please mark any medical conditions you or your family/ blood relatives presently have or have had in the past

Condition	Self	Family	Relation
High Blood Pressure			
Asthma / Hay fever			
Sinus Issues			
Artificial Joint / Heart valve / Prothesis			
Kidney Disease			
Heart Disease			
Rhematic fever			

Condition	Self	Family	Relation
Glaucoma			
Diabetes			
Tubuculosis			
Autoimmune Disease			
Lupis, Rheumatoid Arthritis			
Heart Murmur/Mitral Valve Prolapse			

SELF

Blood Transfusion ◯ Yes ◯ No Date: _____ Hepatitis B or C ◯ Yes ◯ No Do you need antibiotics before dental surgery ◯ Yes ◯ No

Other: _____

Female Only. Are you pregnant? ◯ Yes ◯ No Are you nursing? ◯ Yes ◯ No Do you take birth control? ◯ Yes ◯ No

Date of last menstrual period: _____

SOCIAL HISTORY

6. Do you smoke? ◯ Current everyday ◯ Current somedays ◯ Former smoker ◯ Never smoked ◯ Unknown
7. Do you use any recreational drugs? ◯ Yes ◯ No Please list: _____
8. Do you drink alcohol? ◯ Never ◯ Beer ◯ Wine ◯ Spirits How frequent: _____

List prescriptions / over the counter vitamins and supplements _____

List history of surgeries / hospitalizations _____

_____ _____ _____

(Signature of Patient or responsible party) Printed Name Date

Good faith exam completed: Date: _____ Provider: _____