STEES DERMATOLOGY S.C. CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____Date:_____

Referring Physician: _____ Have you seen Dr. Stees previously? ___ Pharmacy:_____

Reason(s) for visit, please indicate how long, location and what treatments have been used previously:

1. _____
2. _____
3. _____

On this form, Medicare or other entities requires me to ask you any information in **bold**.

Medical and Surgical History

Problem	Y	N	Problem	Y	N
Arthritis			Heart valve disorder		
Chronic Obstructive lung disease (COPD)			Hyperthyroidism		
Depression			Hypothyroidism		
Diabetes			Immunosuppression		
End stage kidney disease			Hepatitis		
Hypertension (high blood pressure)			Lupus		
Human immunodeficiency virus (HIV)			Breast cancer		
High cholesterol			Lung cancer		
Leukemia			Prostate cancer		
Lymphoma			Multiple sclerosis		
Colon cancer			Heart attack		
Anxiety			Radiation therapy		
Asthma			Bone marrow transplantation		
Atrial fibrillation (A-fib)			**Colon removal (partial or whole)**		
Autoimmune disease			Heart bypass surgery		
Cardiac arrhythmia (other than A-fib)			Hysterectomy		
Stroke			Tubal ligation		
Bleeding and clotting disorder			Heart valve replacement		
Coronary artery disease (heart blockages)			Joint replacement surgery		
Epilipsy			Stented artery (heart or elsewhere)		
Family history of autoimmune disease			Kidney transplant		
Gastroesophageal reflux (GERD)			Heart transplant		
Stomach ulcer			Liver transplant		
Tuberculosis (TB) or TB exposure			Pacemaker/defibrillator		

Please list any other medical problems or surgeries not included above: _____

_____

Skin Disease History

Y or N Actinic keratosis (precancerous lesions)
Y or N Basal cell carcinoma (please list location and year treated)

_____

Y or N Atypical or abnormal mole
Y or N Eczema
Y or N Melanoma (please list location, date of treatment, Breslow thickness if known)

_____

Y or N Mohs surgery
Y or N Psoriasis
Y or N Squamous cell carcinoma (please list location and year treated)

_____

Please list other skin problems: _____

Do you use sunscreen or sun protection? If so what SPF or method? _____

Y or N Is there a family history of melanoma? If YES in whom: _____

- PLEASE BRING A CURRENT LIST OF YOUR MEDICATIONS.
- PLEASE LIST ANY ALLERGIES TO DRUGS, MEDICINES, LATEX OR OTHER SUBSTANCES:

_____

- PLEASE LIST ANY OVER THE COUNTER MEDICATIONS OR SUPPLEMENTS YOU TAKE:

_____

Do you smoke? ☐ YES ☐ NO How much? _____

Do you drink alcohol? ☐ YES ☐ NO How much? _____

What is/was your occupation? _____

Female patients only:
Are you pregnant? ☐ YES ☐ NO Are you currently using birth control: ☐ YES ☐ NO
Are you breast feeding? ☐ YES ☐ NO Type of birth control? _____

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