Rockville Internal Medicine Group DERMATOLOGY QUESTIONNAIRE

Printed Patient Name: _____Date of Birth: _____

REASON FOR VISIT: _____Today's Date: _____

HOW DID YOU LEARN ABOUT US?	Referral Name
Primary Care Physician	
Another Dermatologist	
Family/Friend/Co-Worker	
Other (Specify)	

CURRENT MEDICATIONS: (Include Vitamins, Supplements, and over the counter medications)

Drug Name	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

MEDICATION ALLERGIES: ____ **No Known Allergies** If yes, complete below:

Name of Medication	Type of Reaction
	rash difficulty breathing stomach pain/vomiting other:
	rash difficulty breathing stomach pain/vomiting other:
	rash difficulty breathing stomach pain/vomiting other:
	rash difficulty breathing stomach pain/vomiting other:

MEDICAL HISTORY: PLEASE CHECK OR FILL IN ALL PHYSICIAN DIAGNOSED MEDICAL CONDITIONS

Skin Cancer:	**Immunological Disease:**
Melanoma:	Immune Deficiency
Date:	HIV / AIDS
Location:	Lupus or Scleroderma
Squamous Cell Carcinoma:	**Rheumatological Disease:**
Date:	Osteoarthritis
Location:	Rheumatoid Arthritis
Basal Cell Carcinoma:	Gout
Date:	**Psychological / Emotional Disease:**
Location:	Depression
Actinic Keratosis (pre-skin cancer):	Obsessive / Compulsive
Date:	**Gastrointestinal Disease:**
Location:	Cron's Disease, Ulcerative Colitis
Other:	Esophageal Reflux
Date:	Peptic Ulcer
Location:	Esophagitis
Dermatological Disease:	**Cardiovascular Disease:**
Herpes/Cold Sores	High Blood Pressure
Psoriasis	Heart Problems:
Eczema	Heart Attack: Date:
Acne / Rosacea	Pacemaker / AICD
Blistering disorder:	Irregular Heart Beat
Healing Problems: slow keloid bruising	High Cholesterol
Hematology / Oncology:	**Endocrine Disease:**
Cancer; type:	Diabetes
Bleeding Problems	Hyperthyroid / Hypothyroid

Neurological Disease:	Liver Disease:
Stroke / Aneurysm	Hepatitis: Type:
Seizure / Epilepsy	Jaundice
Alzheimer's	**Lung Disease:**
Fainting	Asthma
Kidney Disease:	COPD
Poor Functioning Kidneys	Tuberculosis
Dialysis: type:	**Others: Not Listed:**
For Female Patients:	
Are you pregnant? YES NO	
Are you Planning pregnancy? YES NO	
Polycystic Ovarian Disease	

SURGERIES:

Type of Surgery	Surgeon	Hospital	Date

FAMILY MEDICAL HISTORY: (PLEASE ADD ANY OTHERS NOT LISTED)

Conditions / Problems	Family Members affected and exact nature of problems
Melanoma	
Non-Melanoma Skin Cancer	
Blistering Disorder	
Auto-Immune Disorder	
Psoriasis	

SOCIAL HISTORY / HABITS

Occupation: _____ Active Retired
Smoker: Non-Smoker _____packs/day Quit Smoking in _____
Smokeless Tobacco: YES NO
Alcohol use: NO YES (# of drinks per week _____)
Recreational Drug Use: NO YES _____
Sunscreen Use: Regularly Rarely Never
Outdoor Activity: _____
I have traveled outside the United States in the past three months: YES NO

TANNING / SUN EXPOSURE: (mark what describes you best – mark all that apply)

____ Always burn, never tan
____ Usually burn, tan with difficulty
____ Sometimes burn, usually tan
____ Rarely Burn, Tan easily
____ At least 1 (one) blistering sunburn

Have you ever used a tanning bed, If so, how often: _____ How many years:_____

Patient Printed Name: _____ DOB: _____

REVIEW OF SYMPTOMS: (Please mark all of the symptoms you've been having recently)

General	**Cardiovascular**	**Blood / Lymph**
Weight Gain / Loss	Swelling of Feet/Ankles	Swollen Glands
Loss of appetite	**Musculoskeletal**	Fatigue
Weakness	Joint Pain/Swelling	Varicose Veins
Fevers/Chills/Sweats	Back Pain	
	Muscle Pains/Aches	**Respiratory**
Skin	Neck Pain	Coughing
Skin Rash	Leg Cramps	Wheezing
Itching	Joint Stiffness	Congestion
Lumps	**Allergy**	**Neurological**
Dry/sensitive skin	Runny nose	Numbness/Tingling
Hives	Scratchy throat	Headache
Suspicious moles	Itchy eyes	Seizures
Suspicious lesions	Sinus congestion	Dizziness
Jaundice	Sneezing	**Psychological**
Acne	**Hematology**	Depression
Hair loss	Easy Bruising	High Stress Level
Ears/Nose/Throat	**Gastrointestinal**	Suicidal Thinking
Congestion	Nausea / Vomiting	Eating disorder
Change in voice	Abdominal Pain	Mental or physical Abuse
Nose Bleeds	Change in Bowel Habits	Mood Swings
Drainage From Nose	Heartburn/Indigestion	Obsessive-Compulsive Tendencies
Difficulty Swallowing	**Genitourinary**	
Hoarseness	Pain with Urination	
Sore Throats	Frequent Urination	
Headaches		

Eyes	**Other Medical Problems Not Listed:**
Decreased Vision	
Eye Irritation	
Eye Drainage	
Blurry Vision	
Endocrine	
Excessive Sweating	
Excessive Thirst	
Excessive Urination	
Heat Intolerance	
Cold Intolerance	

Patient Printed Name: _____ DOB: _____

Patient Signature: _____ Date: _____