BAHR DERMATOLOGY HEALTH HISTORY QUESTIONNAIRE

Patient name: _____ **Date:** _____

Were you referred to us? ☐ Yes ☐ No If **YES**, by whom?_____
Who is your primary physician?_____
May we leave a detailed message on your voicemail? **YES** **NO**
What is your favorite music? _____

Have you ever had skin cancer? ☐ Yes ☐ No If **YES**, circle which type: Basal Cell/Squamous Cell/Melanoma/Other
Approximate year_____ How was this treated?:_____

For those over age 65:

Have you **EVER** had your pneumonia vaccine? ☐ Yes ☐ No

Skin Disease History: (please circle below all that apply)

NONE	Blistering Sunburns	Hay Fever/Allergies
Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis

Other_____

Do you wear sunscreen? ☐ Yes ☐ No If **YES**, what SPF?_____

Past Medical History: (please circle all that apply)

NONE			
Anxiety	Colon Cancer	Hearing Loss	Leukemia
Arthritis (type:_____)	COPD	Hepatitis B or C	Lung Cancer
Asthma	Coronary Artery Disease	High Blood Pressure	Lymphoma
Atrial Fibrillation	Depression	HIV/AIDS	Prostate Cancer
Bleeding Disorder	Diabetes	High Cholesterol	Radiation Treatment
Bone Marrow Transplant	End Stage Renal Disease	Hyperthyroidism	Seizures
Breast Cancer	GERD	Hypothyroidism	Stroke

Other_____

Past Surgical History: (please circle all that apply)

NONE		
Appendix Removed	Gallbladder Removed	Prostate Removed for Cancer
Bladder Removed	Coronary Artery Bypass	Prostate Biopsy
Mastectomy (R, L, Both)	Heart Transplant	Prostate Removal (TURP)
Lumpectomy (R, L, Both)	Lung Transplant	Spleen Removed
Breast Implants	Kidney Removed (R, L)	Testicles Removed (R, L, Both)
Colon Surgery for Cancer	Kidney Stone Removal	Hysterectomy for Fibroids
Colon Surgery other cause	Kidney Transplant	Hysterectomy for Cancer
Ovaries Removed for Cancer	Ovaries Removed for other cause	Joint Replacement(s) _____

Other_____

Please indicate whether you have the following:

Difficulty tolerating antibiotics (i.e. nausea) ……	☐ Yes	☐ No
Latex allergy.....	☐ Yes	☐ No
Iodine, Betadine, or IV contrast allergy….....	☐ Yes	☐ No
Nickel allergy or allergy to jewelry.....	☐ Yes	☐ No
Cosmetic product allergy.....	☐ Yes	☐ No
Current sun tanning or tanning bed use.....	☐ Yes	☐ No

Medications: (Please list all current medications, the dose, and how often you take them)

Name of medication	**Dose**	**Frequency**	**Route(i.e. by mouth, injection, etc)**

Please fill out other side →

Allergies: (Please list all allergies, including drug allergies and reactions)

_____

_____

Please answer the following questions about your health habits.

Do you drink alcohol? ☐ Yes ☐ No

Have you ever been a smoker of tobacco/chew tobacco? ☐ Yes ☐ No

If **YES**, when did you start using tobacco? Approx. date: _____

If you have quit using tobacco, when did you quit using tobacco? Approx. date: _____

Number of packs per day? _____

Total years using tobacco? _____

Please note the following about your FAMILY HISTORY:

Melanoma? ☐ Yes ☐ No: If yes, which family member? _____

Asthma? ☐ Yes ☐ No: If yes, which family member? _____

Eczema? ☐ Yes ☐ No: If yes, which family member? _____

Seasonal allergies? ☐ Yes ☐ No: If yes, which family member? _____

Review of Systems: Have you experienced any of the following within the last 10 days?

Problems with bleeding……	☐ Yes	☐ No
Problems with healing ……	☐ Yes	☐ No
Problems with scarring (hypertrophic or keloids)……...	☐ Yes	☐ No
Rash ……	☐ Yes	☐ No
Immunosuppression……	☐ Yes	☐ No
Hay fever……...	☐ Yes	☐ No
Chest pain……...	☐ Yes	☐ No
Fever or chills ……..……	☐ Yes	☐ No
Night sweats……..	☐ Yes	☐ No
Unintentional weight loss……	☐ Yes	☐ No
Thyroid problems ……	☐ Yes	☐ No
Sore throat…….	☐ Yes	☐ No
Blurry vision……...	☐ Yes	☐ No
Abdominal pain…….	☐ Yes	☐ No
Bloody stool……..……..	☐ Yes	☐ No
Bloody urine……..	☐ Yes	☐ No
Joint aches……	☐ Yes	☐ No
Muscle weakness ……...……..	☐ Yes	☐ No
Neck stiffness……	☐ Yes	☐ No
Headaches……	☐ Yes	☐ No
Seizures……	☐ Yes	☐ No
Cough……	☐ Yes	☐ No
Shortness of breath……..	☐ Yes	☐ No
Wheezing……	☐ Yes	☐ No
Anxiety…….	☐ Yes	☐ No
Depression……..	☐ Yes	☐ No

Do you have any of the following? (Please circle all that apply)

Allergy to Adhesive	Blood thinner medication	**Females only:**
Allergy to Lidocaine	Defibrillator	I am pregnant
Allergy to Topical Antibiotics	Pacemaker	I am currently trying to get pregnant
Artificial Heart Valve	I require antibiotics prior to surgeries	I am breastfeeding
MRSA history	I get a rapid heartbeat with epinephrine	

Preferred Pharmacy: _____

Phone Number: _____

City or Zip Code: _____

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