Columbus Skin Surgery Center inc.

Date: ____________________

HEALTH QUESTIONNAIRE

Name____ Date of Birth:____________________

Reason for seeing doctor today: ____

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Location on your body affected: ____

Duration of problem: ____

Who referred you to the office? ____

PAST MEDICAL HISTORY:

Do you have a history of the following conditions? *(Please circle Yes or No for all items)*

Heart Attack . . . . YES NO
Pacemaker . . . . YES NO
Defibrillator . . . . YES NO
Irregular heart beat . . . . YES NO
Artificial heart valve . . . . . . YES NO
Shortness of breath . . . . YES NO
Emphysema . . . . YES NO
High blood pressure . . . . . . YES NO
Organ transplant . . . . YES NO
Tuberculosis . . . . YES NO

Artificial joints . . . . YES NO
Psoriasis . . . . YES NO
PUVA Treatments . . . . YES NO
Keloid scars . . . . YES NO
Healing problems . . . . YES NO
Prior skin cancer . . . . YES NO
Radiation . . . . YES NO
Stroke . . . . YES NO
Seizures . . . . YES NO
Dementia . . . . YES NO

Depression or severe anxiety . . . . YES NO
Bleeding problems . . . . YES NO
Hearing difficulty . . . . YES NO
Aids/HIV infection . . . . YES NO
Diabetes . . . . YES NO
Hepatitis . . . . YES NO
Lymphoma/Leukemia . . . . YES NO
Other medical problems ____________________

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REVIEW OF SYSTEMS:

Do you currently have any of the following? *(Please circle Yes or No for all items)*

Fever . . . . YES NO
Shortness of breath . . . . YES NO
Chest pain . . . . YES NO

Nausea/vomiting . . . . YES NO
Diarrhea . . . . YES NO
Bleeding . . . . YES NO

Enlarged lymph nodes . . . . YES NO
Leg swelling . . . . YES NO

Height: ______________ Weight: ______________

MEDICATION LIST:

Dosage and frequency (including over-the-counter) ____

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MEDICATION ALLERGIES: ____

MAJOR SURGERIES: ____

Do you take any of the following medications? *(Please circle Yes or No for all items)*

Anti-inflammatory medications, such as ibuprofen or naproxen . . . . YES NO
Vitamin E . . . . YES NO
Aspirin . . . . YES NO
Coumadin . . . . YES NO
Plavix . . . . YES NO
Other Blood Thinners: . . . . YES *(List)* ____ NO
Have you been advised to take antibiotics before surgery? . . . . YES NO If yes, Why? ____________________

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Which antibiotic? ____

Do you perform strenuous work? . . . . YES NO
Do you exercise regularly? . . . . YES NO
Smoking, Are you a:
☐ Current smoker ☐ Former smoker ☐ Never smoked
☐ Current everyday smoker ☐ Current some day smoker
How many cigarettes do you smoke per day? ____________________

Are you currently pregnant? . . . . YES NO
Are you breastfeeding? . . . . YES NO
Do you have a history of blistering sunburns? . . . . YES NO
Do you use sunscreen regularly? . . . . YES NO
Have you ever used a tanning bed? . . . . YES NO
How much alcohol do you consume per day? ____________________

FAMILY HISTORY:

Family Member	Date(s) of Birth	Living	Deceased	Medical Problems (including melanoma or other skin cancers)
Father				
Mother				
Brother(s) #				
Sister(s) #				

____ ____

Patient signature line Medical staff signature line