If possible, please fax, send, or bring completed forms with you to the appointment.

PLACER DERMATOLOGY
& Skin Care Center
9285 Sierra College Blvd., Roseville, CA 95661
Phone (916) 784-3376 Fax (916) 784-9500

Patient Health Questionaire

Patient Name: _____ Today's Date: _____
Last *First* *M.I.*

Reason for today's visit:

_____

_____

_____

Did another physician refer you? ◯ Yes ◯ No Name of doctor:_____

How did you find out about Placer Dermatology? Please specify. Thank you.

◯ Family/Friend ◯ Compass ◯ Granite Bay View
◯ Phone Book ◯ Internet ◯ Style Magazine ◯ Other

Current Medications (including prescriptions, over-the counter medications, vitamins and herbals):

_____

_____

Do you have now or have you ever had diseases or conditions of: ☐ No

- ☐ Asthma
- ☐ Bleeding Problems
- ☐ Blood Clots
- ☐ Cancer _____
- ☐ Diabetes
- ☐ Heart Disease _____
- ☐ Heart murmur
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Irregular Heartbeat
- ☐ Keloids (abnormal scarring)
- ☐ Kidney Disease _____
- ☐ Liver Disease/Hepatitis _____
- ☐ Mood disorder _____
- ☐ Respiratory (Lung) Problems _____
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other _____

Have you ever had local anesthesia? ◯ Yes ◯ No Any bad reactions? ◯ Yes ◯ No

Do you require antibiotics for Dental Work? ◯ Yes ◯ No

Do you have any of the following?

☐ artificial heart valve ☐ artificial joints ☐ pacemaker ☐ other metal implants

Do you develop skin rashes in reaction to: ☐ band-aids ☐ topical antibiotic _____

Do you have problems with healing? ◯ Yes ◯ No

Have you ever had any of the following skin cancers? ☐ No

☐ Basal Cell Cancer Location: _____ Treatment and date: _____
☐ Melanoma Location: _____ Treatment and date: _____
☐ Squamous Cell Cancer Location: _____ Treatment and date: _____
☐ Other_____ Location: _____ Treatment and date: _____

List any other Skin Disease you have or had: _____

Are you allergic to any medications? ◯ Yes ◯ No
If yes, list:

_____
_____
_____

List any Major Surgical Procedures and Dates: _____
_____

Family History of Skin Cancer? ◯ Yes ◯ No Type:_____
Family History of Asthma, Seasonal Allergies or Eczema? ◯ Yes ◯ No _____
Family History of any other skin disease ? ◯ Yes ◯ No _____

Social History:
Do you drink alcohol? ◯ Yes ◯ No if yes drinks per day _____
Do you smoke? ◯ Yes ◯ No if yes how much? _____
What is your occupation? _____
Hobbies _____

Do you have or have you recently had any of the following? ☐ No

☐ Bleeding problems	☐ Fever	☐ Shortness of Breath
☐ Cough	☐ Hair Loss	☐ Skin Rash
☐ Depression	☐ Headache	☐ Swollen Lymph Nodes
☐ Dizziness	☐ Joint Pains	☐ Visual Changes
☐ Fatigue	☐ Nausea or Vomiting	☐ Weight loss/gain over 10 pounds

☐ Other symptoms _____

Women only:
Are you pregnant? ◯ Yes ◯ No if yes, how many months? _____
Are you trying to conceive? ◯ Yes ◯ No
Are you breastfeeding? ◯ Yes ◯ No

The above information is correct to the best of my knowledge.

Signature of Patient (Parent or Legal Guardian if Minor):

_____ **Date:** _____

Print Name: _____