

MEDICAL QUESTIONNAIRE

Patient: _____ **Date:** ____/____/____

Why are you coming in to see Dr. Sidney Possick today?

Have you been seen by another dermatologist this year? YES NO

Have you ever been treated for any of the following? (circle one)

- Duodenal or Peptic Ulcers..... YES NO
- Tuberculosis or Lung Disease..... YES NO
- Heart Disease..... YES NO
- High Blood Pressure..... YES NO
- Kidney Disease..... YES NO
- Liver Disease..... YES NO
- Mental Illness or Depression..... YES NO
- HIV/AIDS..... YES NO

Have you ever been treated for a cancer or malignancy? YES NO

If yes, please list what type of cancer and date: _____

Have you ever been diagnosed with serious illness/medical condition? YES NO

If yes, please list _____

Have you ever been treated with (X-Ray) Therapeutic Radiology Treatments to your skin for the treatment of Acne or Skin Cancers? YES NO

Have you or any immediate relative been diagnosed with the following?

- | (Circle) | (List) | |
|-----------|--------|---------------------|
| Asthma | Self | Family Member _____ |
| Hay fever | Self | Family Member _____ |
| Hives | Self | Family Member _____ |
| Eczema | Self | Family Member _____ |
| Diabetes | Self | Family Member _____ |

Do you have a history of over grown scars or keloids? YES NO

Are you allergic to any medications or local anesthetics? YES NO

If yes, please list _____

Please list ALL medications you are taking below (if you take nothing by mouth indicate below N/A) include over the counter products such as aspirin, laxatives, vitamins and herbal supplements _____

