PATIENT QUESTIONNAIRE

Name: _____

1. **ARE YOU ALLERGIC TO ANY MEDICATION (S)? _____ YES _____ NO**
   If yes, please list which one (s).
2. **WHAT IS THE PRIMARY REASON FOR YOUR VISIT TODAY?**
3. **WHERE IS YOUR SKIN PROBLEM LOCATED?**
4. **HOW LONG HAVE YOU HAD THIS CONDITION? (How may days, weeks, months, years?)**
5. **HAVE YOU EVER BEEN TREATED BY ANOTHER PHYSICIAN FOR TODAY'S PROBLEM? IF SO, PLEASE LIST THE PHYSICIAN'S NAME & TREATMENT.**
6. **HAVE YOU EVER TAKEN ANY OTHER MEDICATIONS (S) FOR TODAY'S PROBLEM? IF SO, PLEASE LIST.**
7. **IN YOUR OPINION, HOW IS YOUR GENERAL HEALTH? (excellent, good, fair, poor).**
8. **Are you currently enrolled in any hospice programs? _____YES Date Enrolled_____ _____ NO**
9. **PLEASE LIST ANY OTHER PHYSICIAN'S THAT YOU SEE AND THE CONDITIONS THAT THEY TREAT.**
10. **HAVE YOU EVER HAD SKIN CANCER? _____ YES _____ NO**
11. **HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD SKIN CANCER? _____ YES ____ NO**
12. **DO YOU SMOKE? _____ YES _____ NO**
13. **PLEASE WRITE DOWN THE NAMES OF ALL MEDICATION(S) YOU ARE NOW TAKING, INCLUDING BIRTH CONTROL PILLS OR ERECTILE DYSFUNCTION MEDICATIONS (E.D.).**
14. **HAVE YOU TAKEN ASPIRIN OR OTHER PAIN RELIEVERS IN THE PAST MONTH? _____ YES _____ NO (IF YES, PLEASE LIST THEM AND HOW OFTEN)**
15. **DO YOU TAKE ANY BLOOD THINNERS? _____ YES _____ NO**
    (IF YES, PLEASE LIST WHICH ONE (S)
16. **DO YOU HAVE A PACEMAKER OR IMPLANTED DEFIBRILLATOR? _____ YES ____ NO**
17. **ARE YOU REQUIRED TO TAKE ORAL ANTIBIOTICS PRIOR TO DENTAL WORK? _____ YES _____NO**

FEMALES ANSWER ONLY:

1. **WHEN WAS YOUR LAST MENSTRUAL PERIOD?**
2. **IS THERE ANY POSSIBILITY THAT YOU MAY BE PREGNANT? ____YES ____ NO**
3. **ARE YOU CURRENTLY BREASTFEEDING? _____YES _____ NO**