APDerm® Medical Questionnaire

Patient Name____ **D.O.B.**___________

Date:_______

(please print legibly)

☐ New Patient ☐ Return Patient

Primary Care Physician Name/Address:____

Primary Care Physician Phone#:________________________

Chief Concern:___________________________________ Location:___________________

Duration of Symptoms: (enter #)____ (check one) ☐ Hours ☐ Days ☐ Weeks ☐ Months ☐Years

Severity: (check one) ☐ Same ☐ Worse ☐ Better

What things have you tried to help the problem? **(i.e. topicals, antibiotics, creams, over the counter product, prescriptions)**

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Current Non-Dermatological Problems: (check all that apply)

☐ Anxiety ☐ CHF ☐Depression ☐Diabetes ☐Dizziness ☐Hepatitis ☐HIV ☐Irregular Heart Rhythm ☐ Liver Disease ☐Lymphoma ☐Other_____________________

Surgical History: (check all that apply)

☐Basal Cell Carcinoma ☐Squamous Cell Carcinoma ☐Keloids Removed ☐Melanoma ☐Benign Moles Removed ☐Other Skin Cancer Treatment ☐Aortic Valve Replacement ☐Cancer Treatment ☐Mitral Valve Replacement ☐Pacemaker ☐Other______________________________

Family History: (check all that apply)

☐Acne ☐Basal Cell Carcinoma ☐Squamous Cell Carcinoma ☐Eczema ☐Hair Loss ☐Melanoma ☐Psoriasis ☐Rosacea

Social History: (check all that apply)

Occupation:________________________________ **Smoker**? ☐Current ☐Previous ☐Never Packs Per Day?_____

Alcohol use: ☐Yes ☐No **Sunscreen Use**: ☐Yes ☐No ☐Sometimes SPF?________

Cosmetic Skin Care: Do you have any cosmetic skin care questions today?