ReGenesis Dermatology Confidential Health Questionnaire

Patient Name _____ Date of Birth _____ Age _____

Primary Care Physician _____ Referring Physician _____

Reason for Visit _____

ALLERGIES:

CURRENT MEDICATIONS: (including dietary supplements, nonprescription and herbal products)

CURRENT OR PAST PROBLEMS WITH:

	NO	YES	IF YES, PLEASE EXPLAIN
General Health	□	□	
Asthma/ Allergies	□	□	
Eyes	□	□	
Ears/Nose/Throat/Mouth	□	□	
Heart/ High Blood Pressure	□	□	
Lungs	□	□	
Stomach/ Bowel	□	□	
Kidneys	□	□	
Arthritis	□	□	
Headaches/ Seizures	□	□	
Psychological Disorder	□	□	
Thyroid/ Diabetes	□	□	
Blood Clots/ Bleeding Disorder	□	□	
Autoimmune Disease	□	□	
Hepatitis/ Liver Disease	□	□	
Cancer	□	□	

FAMILY HISTORY:

Number of children ____ Age(s) ____ Mother: Living ___ Deceased ____ Age ____ Father: Living ____ Deceased ____ Age ____

PLEASE CHECK THE FOLLOWING MEDICAL CONDITIONS THAT HAVE OCCURRED IN YOUR FAMILY

DISEASE	MOTHER	FATHER	BLOOD RELATIVE
Asthma/allergies	□	□	□
Diabetes	□	□	□
Heart disease	□	□	□
Lung disease	□	□	□
Cancer	□	□	□
Eczema	□	□	□
Psoriasis	□	□	□
Atypical/dysplastic moles	□	□	□
Melanoma	□	□	□
Skin Cancer	□	□	□
Autoimmune disease	□	□	□

DO YOU HAVE A PERSONAL HISTORY OF SKIN CANCER OR MELANOMA?

No ____ Yes ____

If yes, please tell us the location, type of treatment, and date of treatment:

_____

_____

_____

_____

DO YOU USE SUNSCREEN ON A REGULAR BASIS?

No ____ Yes ____

SOCIAL HISTORY:

Do you smoke or use tobacco? □ No □ Yes

Packs per day _____

Year started _____Year stopped _____

Do you drink alcohol? □ No □ Yes

Drinks per week _____

Do you use recreational drugs? □ No □ Yes

If yes, please explain _____

Marital Status: □ Married □ Single □ Widowed

Current Occupation _____

Females:

Are you currently pregnant? _____

Planning to become pregnant? _____

How did you hear about Dr. Kappius' practice?

□ Internet search □ Primary Care Physician □ Friend □ Flyer □ Social Media □ Other _____

Completed by _____ **Signature/Date** _____