MANHATTAN
DERMATOLOGY

PATIENT HEALTH QUESTIONNAIRE

All information collected in this questionnaire is strictly confidential and will become part of your medical record.
Please bring this completed form with you to your consultation.

PATIENT DATA

Last Name: _____ First Name: _____ Middle Initial: _____

Gender: ☐ Female ☐ Male

Marital Status: _____

Ethnicity:

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

Race:

☐ White
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ Other

PAST MEDICAL HISTORY

Have you had any of the following conditions?

☐ anxiety
☐ arthritis
☐ artificial joints
☐ asthma
☐ atrial fibrillation (irregular heartbeat)
☐ BPH
☐ bone marrow transplantation
☐ breast cancer
☐ colon cancer
☐ COPD
☐ coronary artery disease
☐ depression
☐ diabetes
☐ end stage renal disease
☐ GERD
☐ hearing loss
☐ hepatitis
☐ hypertension
☐ HIV/AIDS
☐ hypercholesterolemia
☐ hyperthyroidism
☐ hypothyroidism
☐ leukemia
☐ lung cancer
☐ lymphoma
☐ prostate cancer
☐ radiation treatment
☐ seizures
☐ stroke

Other: _____

PAST SURGERIES

Have you had any previous surgeries? If so, what and when? _____

SKIN DISEASE HISTORY

Have you had any of the following?

☐ acne
☐ actinic keratoses
☐ asthma
☐ basal cell skin cancer
☐ blistering sunburns
☐ dry skin
☐ eczema
☐ flaking or itchy scalp
☐ hay fever/allergies
☐ melanoma
☐ poison ivy
☐ precancerous moles
☐ psoriasis
☐ squamous cell skin cancer

Other: _____

Do you wear sunscreen? ☐ Yes ☐ No

If yes, what SPF? _____

Do you tan in a tanning salon? ☐ Yes ☐ No

ASHLEY MAGOVERN, MD
board-certified dermatologist

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PATIENT HEALTH QUESTIONNAIRE *(continued)*

FAMILY HISTORY

Do you have a family history of melanoma? ☐ Yes ☐ No If yes, which relative/s? _____

MEDICATIONS

Are you currently on prescription medication? ☐ Yes ☐ No If yes, please list: _____

_____

Do you take over-the-counter drugs, vitamins, supplements, or use inhalers? ☐ Yes ☐ No

If yes, please list: _____

_____

ALLERGIES

Do you have any allergies? ☐ Yes ☐ No If yes, what? _____

SOCIAL HISTORY

Please check all that apply:

☐ Currently smokes ☐ Has smoked in the past ☐ Drug use ☐ Alcohol use

Other: _____

Occupation + Workplace: _____

REVIEW OF SYSTEMS

Do you have any of the following?

- ☐ headaches
- ☐ joint aches
- ☐ fever or chills
- ☐ cough
- ☐ dizziness
- ☐ muscle aches
- ☐ menstrual irregularities
- ☐ sore throat
- ☐ abdominal pain
- ☐ depression
- ☐ thyroid problems
- ☐ rash

ALERTS

Do you have any of the following?

- ☐ pacemaker
- ☐ defibrillator
- ☐ artificial joints (within past 2 years)
- ☐ artificial heart valve
- ☐ premedication prior to procedures
- ☐ difficulty stopping bleeding
- ☐ blood thinners
- ☐ allergy to adhesive
- ☐ allergy to topical antibiotic ointments
- ☐ allergy to lidocaine
- ☐ pregnancy or planning a pregnancy
- ☐ breastfeeding
- ☐ rapid heart beat with epinephrine
- ☐ yeast infection with antibiotics
- ☐ problems with scarring (hypertrophic or keloid)

PATIENT SIGNATURE

Signature: _____ Date: _____

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