

DALLAS DIAGNOSTIC ASSOCIATION  
DERMATOLOGY HEALTH HISTORY QUESTIONNAIRE

The Health History Questionnaire is for you to answer before you are examined by the physician. It contains important information about your health which only you can provide.

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Occupation: \_\_\_\_\_

1. WHAT PROBLEM(S) BROUGHT YOU TO THE DERMATOLOGIST? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. PAST MEDICAL HISTORY (i.e., diabetes, high blood pressure, skin cancer, etc.): (For skin cancer, please write type, location, year treated) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. MEDICATION (Please include any creams/ointments): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4. ALLERGIES TO MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

5. FAMILY HISTORY OF SKIN CANCER OR MELANOMA (please circle):      mother – father – sister – brother- child

6. WHAT TYPE?      (please circle)      basal cell cancer – melanoma – squamous cell cancer

7. DO YOU HAVE      - a pacemaker      yes – no (please circle)

   - an artificial heart valve      yes – no (please circle)

   - abnormal scarring (keloids) yes – no (please circle)

   - do you drink alcohol?      yes – no (please circle)

8. WHO REFERRED YOU TO DERMATOLOGY? \_\_\_\_\_