Columbus Skin Surgery Center inc.

HEALTH QUESTIONNAIRE

Today's Date: _____

Name: _____ Date of Birth: _____

Reason for seeing doctor today: _____

Location on your body affected: _____ Duration of problem: _____

Who referred you to the office? _____

PAST MEDICAL HISTORY:

Do you have a history of the following conditions? *(Please circle Yes or No for all items)*

Heart Attack	YES	NO	Psoriasis	YES	NO	Severe Anxiety	YES	NO
Pacemaker	YES	NO	PUVA Treatments	YES	NO	Bleeding Problems	YES	NO
Defibrillator	YES	NO	Keloid Scars	YES	NO	Hearing Difficulty	YES	NO
Irregular Heart Beat	YES	NO	Healing Problems	YES	NO	HIV Infection	YES	NO
Artificial Heart Valve	YES	NO	Radiation	YES	NO	Diabetess	YES	NO
Shortness of Breath	YES	NO	Stroke	YES	NO	Hepatitis	YES	NO
Emphysema	YES	NO	Seizures	YES	NO	Lymphoma/Leukemia	YES	NO
High Blood Pressure	YES	NO	Basal Cell Carcinoma	YES	NO			
Organ Transplant	YES	NO	Squamous Cell Carcinoma	YES	NO	Other Medical Problems _____		
Tuberculosis	YES	NO	Melanoma	YES	NO	_____		
Artificial Joints	YES	NO	Other Skin Cancer	YES	NO	_____		

REVIEW OF SYSTEMS:

Do you currently have any of the following? (Please circle Yes or No for all items)

Fever	YES	NO	Diarrhea	YES	NO	Enlarged Lymph Nodes	YES	NO
Shortness of Breath	YES	NO	Bleeding	YES	NO	Leg Swellings	YES	NO
Chest pain	YES	NO	Nausea/Vomiting	YES	NO			

Height _____ Weight _____

Please provide separate medication list: Dosage, frequncy and quantity *(including over the counter)*

MEDICATION ALLERGIES: _____

MAJOR SURGERIES: _____

Do you take any of the following medications? *(Please circle Yes or No for all items)*

Anti-inflammatory medications, such as ibuprofen or naproxen						Vitamin E	YES	NO
Aspirin	YES	NO	Coumadin	YES	NO	Plavix	YES	NO
Other Blood Thinners:	YES (List) _____							NO
Have you been advised to take antibiotics before surgery?						If yes, Why? _____		

_____

Which antibiotic? _____

Do you perform strenuous work?	YES	NO	Are you currently pregnant?	YES	NO
Do you exercise regularly?	YES	NO	Are you breastfeeding?	YES	NO
Smoking or Vaping:			Do you have a history of blistering sunburns?	YES	NO
☐ Current smoker ☐ Former smoker ☐ Never smoked			Do you use sunscreen regularly?	YES	NO
☐ Current everyday smoker ☐ Current some day smoker			Have you ever used a tanning bed?	YES	NO
How many cigarettes do you smoke per day? _____			How much alcohol do you consume per day? _____		

FAMILY HISTORY OF MELANOMA: YES NO

SOCIAL DRIVERS: Do you have any concerns with the following?

- ☐ Food Insecurity
- ☐ Housing Stability
- ☐ Transportation Needs
- ☐ Utility Difficulties
- ☐ Interpersonal Safety
- ☐ None Apply
- ☐ Decline To Answer

ADVANCED CARE: Please mark what applies

- ☐ Full Code
- ☐ Do Not Resucitate (DNR)
- ☐ Do Not Intubate
- ☐ Living Will
- ☐ Healthcare Proxy: If yes, list name _____

_____

Patient Signature Line _____