

INTEGRATED  
DERMATOLOGY  
OF WATERBURY

Jeffrey Alter, MD • Rui Cheng, MD

HEALTH QUESTIONNAIRE

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Referred By: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Reason for Your Visit: \_\_\_\_\_

Duration of Problem: \_\_\_\_\_

Treatment: \_\_\_\_\_

Aggravating Factors: \_\_\_\_\_

Current Medications (please include over-the-counter, herbs, vitamins, supplements): \_\_\_\_\_

Allergies to Medication:  None  \_\_\_\_\_

Other Allergies:  None  Latex  Bandages/Adhesive  
 Topical Antibiotic (Neosporin or other) \_\_\_\_\_

Have you ever had a bad reaction to local anesthesia?  No  Yes  Never had anesthesia

FOR WOMEN ONLY:

Are you currently pregnant, trying to become pregnant, or are you nursing? \_\_\_\_\_

Are you on a contraceptive, and if so, what form? \_\_\_\_\_

SKIN CONDITIONS:

Have you ever had skin cancer?  No  Yes  
If Yes,  Basal Cell Cancer  Squamous Cell Cancer  Melanoma

Where? \_\_\_\_\_ When? \_\_\_\_\_

Treatment? \_\_\_\_\_

Has anyone in your family ever had skin cancer?  No  Yes  
If Yes,  Basal Cell Cancer  Squamous Cell Cancer  Melanoma

Who? \_\_\_\_\_

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Do you have any history of skin problems or diseases?  No  Yes

If Yes,  Psoriasis  Eczema  Keloid  Other \_\_\_\_\_

SUN EXPOSURE:

When you are exposed to the sun do you:

- always burn  rarely burn, always tan well  
 usually burn, tan minimally  very rarely burn, tan very easily  
 sometimes mild burn, tan uniformly  never burn, tan very easily

Where did you grow up? \_\_\_\_\_

Did you:  sunburn every summer in childhood  
 get at least one blistering sunburn, how many \_\_\_\_\_  
 ever use a tanning bed, how many times/how often \_\_\_\_\_

Do you:  Use sunscreen regularly, SPF \_\_\_\_\_

PAST SURGERIES (Type and Date): \_\_\_\_\_

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS:

Allergic/Immunologic:  Normal  Seasonal allergies  Immunosuppression  
 Autoimmune problem

Constitutional:  Normal  Weight loss/weight gain  Fever/Night sweats  Fainting

Cancer: Type \_\_\_\_\_

Cardiovascular:  Normal  Artificial Heart Valve  Pacemaker  
 Implanted Defibrillator  Irregular Heartbeat  
 Chest Pain/Heart attack  Mitral Valve Prolapse  
 Other \_\_\_\_\_

Ears/Eyes/Nose:  Normal  Glaucoma  Glasses/Contacts  Other \_\_\_\_\_

Endocrine:  Normal  Diabetes  Thyroid Disease  Other \_\_\_\_\_ Gastrointestinal:  
 Normal  Reflux  Liver Problem  Nausea  Diarrhea  
 Other \_\_\_\_\_

Genital/Urinary:  Normal  Enlarged Prostate  Prostate Cancer

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Hematologic:  Normal  Anemia  Bleeding Problems  Other \_\_\_\_\_

Infections:  Normal  HIV  Hepatitis  Tuberculosis/+PPD Skin Test  
 Other \_\_\_\_\_

Musculoskeletal:  Normal  Arthritis  Artificial Joint  Other \_\_\_\_\_

Neurological:  Normal  Stroke  Seizures/Epilepsy  Multiple Sclerosis  
 Other \_\_\_\_\_

Respiratory:  Normal  Asthma  Emphysema  Other \_\_\_\_\_

Psychiatric:  Normal  Depression  Anxiety Attacks  Other \_\_\_\_\_

Others:  Kidney Problems  Cold Sores  Varicose Veins  
 Require Antibiotics Prior to Dentistry

Any other medical problems: \_\_\_\_\_

FAMILY HISTORY:  Eczema  Psoriasis  Other \_\_\_\_\_

COSMETIC HISTORY:  BOTOX Injectable Fillers  Laser Treatments

SOCIAL HISTORY:

Marital Status:  Single  Married  Divorced  Widow/Widower

Occupation: \_\_\_\_\_

Smoking:  No  Former  Yes, packs/day \_\_\_\_\_

Alcohol:  No  Yes, how much/often \_\_\_\_\_

By signing, I am acknowledging that I have disclosed all of my health information known to me at this time, and all of my other personal information is accurate. I understand that it is my obligation and responsibility to notify Integrated Dermatology of Waterbury of any changes in my medical information during the course of my medical treatment.

SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_