

SOUTHEASTERN DERMATOLOGY, P.A.
4390 Fayetteville Road
Lumberton, North Carolina 28358

PATIENT QUESTIONNAIRE

PATIENT'S NAME _____ **CHART #** _____ **DATE** _____

CHIEF COMPLAINT Reason for your visit today: _____

PAST MEDICAL HISTORY

Are you allergic to any medications or other substances? Yes _____ No _____ If Yes, please list: _____

Medications that you currently are taking including vitamins, aspirin, etc.: _____

List any surgical procedures you have had: _____

List any disease or conditions that you have or are receiving treatment for: _____

PAST MEDICAL HISTORY Check **Yes** if you have or have had any of these problems.

	Yes	If Yes, please explain
Asthma / Hay fever / Eczema	_____	_____
Bleeding disorder / tendency	_____	_____
Scarring / Keloid tendency	_____	_____
Eye / Ear / Nose / Throat disease	_____	_____
High Cholesterol	_____	_____
High blood pressure	_____	_____
Heart disease / Rheumatic fever history	_____	_____
Pacemaker / Heart murmur	_____	_____
TB (Tuberculosis)	_____	_____
Diabetes	_____	_____
Thyroid disease	_____	_____
Hepatitis / Liver disease	_____	_____
Kidney / Urine disease	_____	_____
Arthritis / Joint deformity	_____	_____
Collagen / Vascular disease / Lupus	_____	_____
HIV / AIDS	_____	_____
Stroke / Seizures / Epilepsy	_____	_____
Psychiatric disorder	_____	_____
Hair loss / increased	_____	_____
Psoriasis / Skin disease	_____	_____
Skin cancer / Melanoma	_____	_____
Other Cancer	_____	_____

PATIENT NAME: _____ CHART # _____ DATE _____

REVIEW OF SYSTEMS Check YES if you have or have had any of these problems.

	Yes		Yes
GENERAL		GASTROINTESTINAL	
Fever	_____	Abdominal Pain	_____
Weight loss	_____	Nausea	_____
Fatigue	_____	Bloody / Black stools	_____
Night sweats	_____	Other	_____
Other	_____		
EYES		GENITOURINARY	
Itching	_____	Painful / Difficulty with urination	_____
Scratching sensation	_____	Blood in urine / Change in urine	_____
Excess tears	_____	Other	_____
Other	_____		
EAR / NOSE / THROAT		MUSCULOSKELETAL	
Bleeding	_____	Bone pain	_____
Pain	_____	Arthritis	_____
New Growths	_____	Other	_____
Other	_____		
LUNGS		SKIN	
Cough	_____	New growths or nodules	_____
Shortness of breath	_____	Other changing skin lesions	_____
Other	_____	Hair loss / increased	_____
		Other	_____
HEART		LYMPHATIC	
Chest pain	_____	Enlarged lymph nodes	_____
Leg swelling	_____	Other	_____
Leg pain with exercise	_____		
Other	_____	NEUROLOGIC	
ALLERGIC		Burning sensation	_____
Allergic to Lidocaine	_____	Headaches	_____
Other	_____	Weakness	_____
		Visual problems	_____
HEMATOLOGIC		Other	_____
Bleeding Problems	_____	PSYCHIATRIC	
Anemia	_____	Depression	_____
Other	_____	Anxiety	_____
		Other	_____

FEMALES ONLY : Are you pregnant ? Yes___ No___ Planning to become pregnant ? Yes___ No___

Are you breast feeding ? Yes___ No___ When was your last menstrual period?_____

Are your menstrual periods regular each month ? Yes___ No___

PATIENT NAME: _____ CHART# _____ DATE _____

FAMILY HISTORY

Check **Yes** if the following conditions have occurred in your immediate blood relatives. Please specify their relationship to you. (e.g. father, mother, brother, sister etc.)

Yes	FAMILY MEMBERS
Asthma/ Hay fever/ Eczema	_____
Bleeding disorder / tendency	_____
Scarring /Keloid tendency	_____
Arthritis / Joint deformity	_____
Collagen Vascular disease / Lupus	_____
Diabetes	_____
High cholesterol	_____
High blood pressure	_____
Heart disease	_____
TB (Tuberculosis)	_____
HIV / AIDS	_____
Seizures / Epilepsy	_____
Stroke	_____
Hair loss / increased	_____
Psoriasis / Skin disease	_____
Skin cancer / Melanoma	_____
Other Cancer	_____

SOCIAL HISTORY

Do you drink alcohol? Yes _____ No _____ If Yes, how much? _____
Do you use tobacco? Yes _____ No _____ If Yes, what type and how much? _____
Do you use illegal drugs? Yes _____ No _____

What is your occupation? _____

What is your hobbies / sports? _____

Do you use a tanning bed? Yes _____ No _____

Do you use a sunscreen? Never _____ Rarely _____ Occasionally _____ Usually _____ Daily _____

What soap do you use? Body _____ Face _____

What kind of shampoo do you use? _____

Do you use moisturizers? If Yes, what kind? _____

Laundry detergent, what kind? _____ Fabric Softeners? _____

Make up? what brand? _____

Patient's Signature

Reviewing Nurse's Signature

Date