

Morgana Colombo, 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 Reston, LLC of any changes in my medical information during the course of my medical treatment.

❖ SIGNATURE _____ Date _____