Dermatology Clinic Health History Questionnaire

Name ____ Date_____________

Date of Birth _____________ E-mail____

Welcome to the UW Dermatology Center. We are very pleased you chose us for your care. Thank you.

FOLLOW-UP: When we contact you about results related to your visit is a detailed phone message ok?

□ Yes □ No If yes, preferred number________________________________

Chief Complaint - Please describe the problem that brings you into the office today:

Allergies

1. Do you have any allergies? □ Yes □ No If so, please list
   To **Medications?** ____
   To **Foods?** ____
2. Are you allergic to **latex?** □ Yes □ No

Medications

Please list any prescription drugs you are taking?

Medications	Dose	Times per day	Reason for taking
______________________	_____________	_______________	_____________________________
______________________	_____________	_______________	_____________________________
______________________	_____________	_______________	_____________________________
______________________	_____________	_______________	_____________________________
______________________	_____________	_______________	_____________________________
______________________	_____________	_______________	_____________________________
______________________	_____________	_______________	_____________________________
______________________	_____________	_______________	_____________________________

Over-the-Counter Medications □ None	Dose	Times per day	Reason for taking
_____________________	_____________	______________	____________________________
_____________________	_____________	______________	____________________________

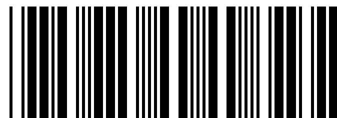
Herbs, Vitamins, Minerals, etc. □ None	Dose	Times per day	Reason for taking
____________________	____________	_____________	____________________________
____________________	____________	_____________	____________________________

Pharmacy Name:_________________________________ Phone #___________________________________

PLACE PATIENT LABEL HERE

UW Medicine
Harborview Medical Center – University of Washington Medical Center
UW Medicine Primary Care – Valley Medical Center – UW Physicians

DERMATOLOGY CLINIC HEALTH HISTORY QUESTIONNAIRE



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Social History

Occupation____________________________ Where did you grow up? ________________________________

Who do you live with? (check all that apply) ☐ I live alone ☐ Spouse/Partner ☐ Children ☐ Parents ☐ Other

Do you have pets? ☐ Yes ☐ No

Habits and Risk Factors

Tobacco Use ☐ Never ☐ Past ☐ Current ☐ Passive

Marijuana Use ☐ Never ☐ Past Types: ☐ Smoking ☐ Vaping ☐ Edibles ☐ Topicals

Alcohol Use ☐ Never ☐ Past ☐ Current **Drinks per week** ___________________

Other Drug Use ☐ Never ☐ Past ☐ Current Types: ☐ Amphetamines/Meth ☐ Cocaine ☐ Benzodiazepines ☐ Opioids ☐ Hallucinogens ☐ Anabolic Steroids

Yes	No	**SKIN HISTORY**
☐	☐	Have **YOU** had skin cancer?
		☐ Basal cell carcinoma
		☐ Squamous cell carcinoma
		☐ Melanoma
		☐ unknown
☐	☐	Family history of skin cancer If yes, who? (mother, sister, son, etc.) ____________________
		☐ Basal cell carcinoma
		☐ Squamous cell carcinoma
		☐ Melanoma
		☐ unknown
☐	☐	History of serious sunburn(s)
☐	☐	History of tanning beds, Ultraviolet lights
☐	☐	Do you use sunscreen regularly?
☐	☐	Do you wear hats in the sun?
☐	☐	History of ionizing radiation
☐	☐	History of asthma
☐	☐	History of eczema
☐	☐	History of seasonal allergies

HEALTH HISTORY:
Have you had any of the following:

Yes	No	
☐	☐	Organ or stem cell transplant
☐	☐	Cancer (type)____________________
☐	☐	Heart murmur
☐	☐	High blood pressure
☐	☐	Liver disease, jaundice, hepatitis
☐	☐	Depression or other mental illness
☐	☐	Artificial joints or heart valves
☐	☐	Do you take antibiotics when you go to the dentist?
☐	☐	Diabetes
☐	☐	Tuberculosis (TB)
☐	☐	Uncontrolled bleeding
☐	☐	Stroke
☐	☐	Blood clot
☐	☐	HIV
☐	☐	Raynaud's (problems with your fingers when you go out in the cold)
☐	☐	Thyroid disease
☐	☐	Sexually transmitted infection

PLACE PATIENT LABEL HERE