NOVATO DERMATOLOGY

867 DIABLO AVENUE
Novato, CA 94947-4367
PH: (415) 892-0754 FX: (415) 897-3204

HEALTH QUESTIONNAIRE

First Name: ____________________ Middle Initial: _____ Last Name: ____________________________________

Date of Birth: ____________

Primary care doctor: ____________ Referring doctor: ______________ Pharmacy: _______________

CURRENT MEDICATIONS (INCLUDING OVER-THE-COUNTER MEDICATIONS AND VITAMINS)		
MEDICATION NAME	***DOSAGE***	***# OF TIMES DAILY***

MEDICATION ALLERGIES	
❑ **NO KNOWN DRUG ALLERGIES**	
NAME OF MEDICATION	***REACTION (ex: hives, itching)***

	BLOOD THINNERS – OTC and RX - CHECK ALL THAT APPLY		
❑	Aspirin 325mg	❑	Plavix (Clopidrogel)
❑	Aspirin 81mg	❑	Lovenox (Enoxaparin Sodium)
❑	Ibuprofen (Advil, Motrin)	❑	Brilinta (Ticagrelor)
❑	Aleve (Naproxen)	❑	OTHER (**Please name**)
❑	Fish Oil		
❑	Turmeric		
❑	Vitamin E capsule (DIFFERENT than multivitamin)		
❑	Ginkgo		
❑	Ginseng		
❑	Warfarin/Coumadin		
❑	Xarelto		
❑	Pradaxa		
❑	Eliquis		

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	PAST MEDICAL HISTORY (SELECT ALL THAT APPLY) PLEASE SPECIFY IF APPLICABLE		
❑	**NONE OF THE FOLLOWING APPLY**	❑	High Cholesterol
❑	Asthma	❑	HIV
❑	Autoimmune Disorder	❑	Pacemaker ❑ Defibrillator
❑	Cancer - Breast	❑	Peptic Ulcers
❑	Cancer - Colon	❑	Planning future pregnancy
❑	Cancer - Lung	❑	Radiation Therapy
❑	Cancer-Other	❑	Shingles
❑	Dementia	❑	Stroke
❑	Diabetes	❑	Thyroid Disorder
❑	Gout	❑	Tuberculosis
❑	Heart Disease	❑	Other History
❑	Hepatitis – Type: ______________		
❑	High Blood Pressure		

ADDITIONAL MEDICAL HISTORY – CHECK ALL THAT APPLY	
❑	**NONE OF THE FOLLOWING APPLY**
❑	Atrial Fibrillation “A-FIB”
❑	History of Blood Clots
❑	Stents
❑	Have an artificial heart valve.
❑	Have an artificial joint(s). ❑ Knee(s) ❑ Hip(s)
❑	Have a Heart Murmur
❑	Have a Mitral Valve Prolapse.
❑	Have a History of Endocarditis.
❑	Pacemaker
❑	Defibrillator
❑	Have Hepatitis A
❑	Have Hepatitis B
❑	Have Hepatitis C
❑	Have HIV ❑ AIDS

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	PAST SKIN HISTORY	
❑	**NONE OF THE FOLLOWING APPLY**	
❑	Actinic Keratosis (Pre-Cancers)	
❑	Basal Cell Carcinoma	
❑	Squamous Cell Carcinoma	
❑	Keratoacanthoma	
❑	Malignant Melanoma	
❑	Dysplastic Nevus	
❑	Eczema	
❑	Psoriasis	
❑	Acne	
❑	Hives/Urticaria	
❑	UV Light Treatment for Acne	
❑	X-Ray Treatment for Acne	
❑	Other skin history	

YES	NO	TANNING BED
❑	❑	**Have you ever used a tanning bed?**

	FAMILY HISTORY	
❑	**NO FAMILY HISTORY**	
❑	Malignant Melanoma	
❑	Squamous Cell Carcinoma	
❑	Basal Cell Carcinoma	
❑	Asthma	
❑	Eczema	
❑	Autoimmune Disorders	
❑	Hayfever/Seasonal Allergies	
❑	Lupus	
❑	Other Autoimmune Disorders	
❑	X-Ray Treatment for Acne	
❑	Other Skin History	

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SURGERIES/HOSPITALIZATIONS (ONLY IN THE PAST 10 YEARS)	
☐ NONE	
SURGERY	**DATE**

PERSONAL HISTORY	
Alcohol Use:	❑ Never drink alcohol ❑ Occasionally drink alcohol ❑ Drink alcohol daily
Tobacco Use:	❑ Current every day smoker ❑ Current some day smoker ❑ Former smoker ❑ Never smoker ❑ Smoker, current status unknown ❑ Unknown if ever smoked ❑ Heavy tobacco smoker ❑ Light tobacco smoker Date Started: ___________________ Date Ended: ___________________

SOCIAL HISTORY	
Marital Status:	❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Domestic partner
Occupation:	
Hobbies:	
Recent Travel:	