



College Park Family Care Center, P.A.
Dermatology Department

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MEDICAL QUESTIONNAIRE: INITIAL EVALUATION

Patient Name: _____ Birth Date: _____ Today's Date: _____

NAME AND ADDRESS _____
 OF REFERRING PHYSICIAN _____

A. HAVE YOU EVER HAD OR BEEN TREATED FOR ONE OF THE FOLLOWING?	YES	NO
1. Heart disease (murmur, rheumatic fever, valve disease, pacemaker)	_____	_____
2. A heart attack or angina	_____	_____
3. High Blood pressure	_____	_____
4. Duodenal or peptic ulcer	_____	_____
5. Intestinal or stomach disease colitis	_____	_____
6. Liver or gallbladder disease	_____	_____
7. Lung disease (tuberculosis, asthma, pneumonia)	_____	_____
8. Stroke	_____	_____
9. Kidney disease	_____	_____
10. Urinary or bladder problem or infection	_____	_____
11. Venereal disease (sexually transmitted disease)	_____	_____
12. Blood disorder or lymph gland disorder	_____	_____
13. Eye disorder (glaucoma, cataract, cataract surgery)	_____	_____
14. Arthritis, joint problem bone disease	_____	_____
15. Diabetes, thyroid disease or other endocrine problems	_____	_____
16. Thrombophlebitis	_____	_____
17. Cancer/Leukemia	_____	_____
18. Frequent infections (skin or other)	_____	_____
19. Neurological disorder	_____	_____
20. Emotional, nervous or psychiatric condition	_____	_____
21. HIV infection/AIDS or have reason to believe you may be infected	_____	_____
22. Hepatitis or have reason to believe you may be infected	_____	_____
23. A blood transfusion	_____	_____
24. An artificial valve or joint	_____	_____
25. Any other medical problems not listed above? If yes, explain.	_____	_____

B. HAVE YOU OR ANY MEMBER OF YOUR FAMILY (SPECIFY WHO) EVER HAD:	YOU		FAMILY MEMBERS		WHO?
	YES	NO	YES	NO	
1. Asthma	_____	_____	_____	_____	_____
2. Hay fever	_____	_____	_____	_____	_____
3. Eczema	_____	_____	_____	_____	_____
4. Hives	_____	_____	_____	_____	_____
5. Diabetes	_____	_____	_____	_____	_____
6. Psoriasis	_____	_____	_____	_____	_____
7. *Skin cancer	_____	_____	_____	_____	_____
8. Other skin conditions (specify)	_____	_____	_____	_____	_____

*If the answer is YES, what type of skin cancer? _____

Continued on next page...

C. HAVE YOU EVER HAD:

- 1. Excessive bleeding when cut
- 2. Difficulty with healing of wounds
- 3. Overgrown scars or keloids
- 4. Allergy to local anesthetics

YES NO

_____	_____
_____	_____
_____	_____
_____	_____

D. Have you previously had a skin problem or been under the care of a dermatologist? YES NO
If yes, please describe:

E. Have you ever been given radiation therapy (x-ray or Grenz ray treatments) to your skin? YES NO
If yes, please explain:

When: _____ Where: _____ How Long: _____

F. Do you take any medications, drugs, over-the-counter preparations or remedies? YES NO
If yes, please list the names of the medicines. If you do not know the names bring in the name at the time of your next appointment (include aspirin, pain relievers, laxatives, vitamins, etc.).

G. Are you required to take antibiotics before going to the dentist? YES NO

H. Are you allergic to any medicines, drugs, antibiotics over-the-counter preparations or remedies? YES NO
If yes, please list what you are allergic to and what your reaction was:

I. Prior Hospitalization and Surgery (Give approximate dates and reason):

- J.**
- 1. Do you smoke? _____ How much? _____
 - 2. Do you drink alcohol? _____ How much? _____
 - 3. Do you take any illicit street drugs? If so, what and how much? _____
 - 4. What is your occupation? _____
 - 5. Do you have any hobbies? _____ What? _____

K. FOR FEMALE PATIENTS ONLY:

- 1. Have you had vaginal yeast infections? _____
- 2. Are you pregnant or nursing? _____
- 3. Are you currently planning a pregnancy? _____
- 4. What form of birth control do you now use? _____
- 5. When was your last menstrual period? _____

YES NO

PLEASE INFORM THE DOCTOR AT ANY TIME IF YOU PLAN TO BECOME PREGNANT DURING YOUR TREATMENT. UNLESS YOU ARE TOLD SPECIFICALLY THAT A TREATMENT IS SAFE DURING PREGNANCY, IF YOU BECOME PREGNANT OR ARE NURSING, THEN ASSUME THAT THE TREATMENT IS NOT SAFE AND DISCONTINUE IT.

L. Is there anything else we should know about you?
