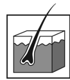

Robert K.P. Chow, M.D.
DIPLOMATE, AMERICAN BOARD OF DERMATOLOGY
Medical and Aesthetic Dermatology, Surgery, and Phototherapy

Health Questionnaire

Name:____________________

Age:__________

Your Occupation:____________________

Past skin problems **If none, check here:** ❒

- ❒ Abnormal moles
- ❒ Melanoma
- ❒ Other skin cancer
- ❒ Eczema or dermatitis
- ❒ Hayfever or asthma
- ❒ Other – specify
- ❒ Psoriasis
- ❒ Thick scars or keloids

Does anyone in your family have any of the above skin problems? ❒ No

❒ Yes – specify____________________

Do you have any of the following **medical conditions**? **If none, check here:** ❒

- ❒ Heart murmur
- ❒ Excessive bleeding/clotting
- ❒ Thyroid problems
- ❒ Arthritis
- ❒ Artificial heart valve or joint
- ❒ Hepatitis
- ❒ Diabetes
- ❒ Cancer (type?)
- ❒ Pacemaker
- ❒ AIDS or HIV infection
- ❒ Kidney problems

Others:____________________

Surgeries in the last 12 months:____________________

Do you currently take any **medications** (including non-prescription & vitamins)? **If none, check here:** ❒

Do you have any **allergies** to medication (including Novacaine)? **If none, check here:** ❒

Name of Drug Describe the reaction (eg., rash, difficulty breathing)

Do you need to take antibiotics before routine dental cleaning? *(Please circle one)* Yes No

Habits: Alcohol Tobacco IV Drugs Aspirin

Women Only:

Are you pregnant (or trying)? *(Please circle one)* Yes No Not sure

Are you currently breast-feeding? *(Please circle one)* Yes No

Birth Control method (if any):____________________

Thank you for completing this form!

Your Signature:____________________ Date:__________