PATIENT HEALTH QUESTIONNAIRE

Patient Name:______________________________ **DOB:**____ / ____ / ____ **Date:** ____ / ____ / ____

Pharmacy (name/town/phone #): ______________________________

Referring/Primary Care Dr. ______________________________ **Last Visit Date:**________________

Past Medical History: (please check all that apply)

☐ Anxiety	☐ Diabetes	☐ Hyperthyroidism
☐ Arthritis	☐ End Stage Renal Disease	☐ Hypothyroidism
☐ Asthma/Breathing Disorder	☐ GERD	☐ Leukemia
☐ Atrial Fibrillation	☐ Head Trauma	☐ Lung Cancer
☐ Bone Marrow Transplant	☐ Hearing Loss	☐ Lymphoma
☐ BPH	☐ Heart Disease	☐ Prostate Cancer
☐ Breast Cancer	☐ Hepatitis	☐ Radiation Treatment
☐ Colon Cancer	☐ Hypertension	☐ Seizures
☐ COPD	☐ HIV / AIDS	☐ Stroke
☐ Depression	☐ Hypercholesterolemia	
☐ **Other:**		

Past Surgical History: (please list all previous surgeries)

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Family History: (please check all that apply)

☐ Melanoma	☐ Mom	☐ Dad	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐ Non-Melanoma Skin Cancer	☐ Mom	☐ Dad	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐ Diabetes	☐ Mom	☐ Dad	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐ High Cholesterol	☐ Mom	☐ Dad	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐ High Blood Pressure	☐ Mom	☐ Dad	☐ Sister	☐ Brother	☐ Daughter	☐ Son

Additional Family History: ______________________________

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Skin Disease History: (please check all that apply)

☐ Acne	☐ Dry Skin	☐ Poison Ivy
☐ Actinic Keratosis	☐ Eczema	☐ Precancerous Moles
☐ Asthma	☐ Flaking/Itchy Scalp	☐ Psoriasis
☐ Basal Cell Skin Cancer	☐ Hay Fever/Allergies	☐ Squamous Cell Skin Cancer
☐ Blistering Sunburns	☐ Melanoma	
☐ **Other:**		

DO YOU WEAR SUNSCREEN? ☐ YES ☐ NO What SPF:_____ **DO YOU TAN IN A TANNING SALON?** ☐ YES ☐ NO

TURN OVER TO COMPLETE FORM

PATIENT HEALTH QUESTIONNAIRE cont.

REVIEW OF SYSTEMS: Are you currently experiencing any of the following? (please check yes or no)

Symptom	Yes	No
Are you in generally good health?		
Do you have problems with bleeding?		
Do you have problems with healing?		
Do you have problems with scarring?		
Do you currently have a rash?		
Do you have any new skin lesions?		
Do you have any changing skin lesions?		

MEDICATIONS/VITAMINS/SUPPLEMENTS: (please provide current list of medications) ☐ NO MEDICATIONS

Name: ______________________ Strength: __________ Frequency: __________

Name: ______________________ Strength: __________ Frequency: __________

Name: ______________________ Strength: __________ Frequency: __________

Name: ______________________ Strength: __________ Frequency: __________

Name: ______________________ Strength: __________ Frequency: __________

DRUG & FOOD ALLERGIES: (please list all known allergies and reactions)

☐ NO KNOWN DRUG ALLERGIES
☐ NO KNOWN FOOD ALLERGIES

______________________ ______________________

______________________ ______________________

SOCIAL HISTORY:

Smoking Status: ☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker

Alcohol Use: ☐ None ☐ < 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

Occupation: ______________________________

ALERTS: (please check all that apply)

☐ Allergy to Adhesive	☐ Artificial Joint Replacement	☐ MRSA
☐ Allergy to Latex	☐ Blood Thinners	☐ Pacemaker
☐ Allergy to Lidocaine	☐ Defibrillator	☐ Require Antibiotics Prior to Procedure
☐ Artificial Valve Replacement	☐ Keloid Scarring	☐ Rapid Heartbeat with Epinephrine

1. **Did you receive a COVID 19 vaccination this season?** ☐ YES ☐ NO
2. **If you are between your 11th and 13th birthday, have you received your meningococcal vaccine?** ☐ YES ☐ NO
3. **If you are between your 10th and 13th birthday, have you received your Tdap vaccine?** ☐ YES ☐ NO
4. **If you are between your 9th and 13th birthday, have you received your HPV vaccine?** ☐ YES ☐ NO
5. **ARE YOU PREGNANT OR CURRENTLY TRYING TO GET PREGNANT?** ☐ YES ☐ NO
6. **Do you have an Advanced Care Plan?** ☐ YES ☐ NO

AND/OR Who is your surrogate medical decision maker:

Name: ______________________________ **Phone Number:** ______________