Dermatological Center for Skin Health at St. John's Health Center
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Medical Questionnaire

Date: _____

Name: _____ Current gender identity_____
Last First Middle
Sex assigned at birth: □ Male □ Female Age: _____ Birth-date: _____ Birth Place: _____
Mother's Birth Name: _____
Marital Status: □ Single □ Married ~ Spouse's Name _____
□ Divorced □ Separated □ Widowed
Language Preferred: _____ Interpreter Requested? □ Yes □ No
Home Address: _____
City: _____ State: _____ Zip-code: _____-_____
Phone: _____Fax: _____
Other important self-identifying factors including pronouns: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____
(Not living in the same household)
Address:_____
City: _____ State: _____ Zip-code: _____-_____

Phone: _____ Fax: _____

Local Telephone Number if not local to Los Angeles: (Relative, Friend or Hotel) _____

1. Primary Care Physician: _____
   Specialty: _____
   Address: _____
   City: _____ State: _____Zip-code: _____-_____
   Phone: _____ Fax: _____

2. Referring Physician (if other than #1): _____
   Specialty: _____
   Address:_____
   City: _____ State: _____Zip-code: _____-____
   Phone: _____ Fax: _____

3. Other Physician:_____
   Specialty: _____
   Address:_____
   City: _____ State: _____Zip-code: _____-____
   Phone: _____ Fax: _____

*** Periodic reports may be sent to your physician(s). Please circle number(s) of any physician you wish to receive reports.**

Height: _____ Weight:_____

Allergies:

Category	*Yes*	*No*	*Do Not Know*	*List Specific item (for example. sulfa, eggs, dust mites)*	*What happens (for example, rash, swelling, itchy eyes)?*
Drugs					
Food					
Environmental					

Present Illness

Please describe in your own words the date of onset of your illness, symptoms & treatment.

How long have you had symptoms? Are they constant or do they come and go?

What makes it worse?

Has anything made it better?

What is your goal for today's visit?

Please indicate if you have had or currently are experiencing any of the following. If you are not sure, please mark "Do Not Know"

GENERAL

	Condition	YES	NO	Do Not Know
1.	Fever/Chills			
2.	Swollen or enlarged (lymph) glands			
3.	Unintentional Weight Loss			
4.	Unintentional Weight Gain			
5.	Night sweats (soaking the sheets)			
6.	Fatigue			
7.	Insomnia			
8.	Loss of appetite			
9.	Cancer			
10.	Infectious disease			
11.	Pain			

SKIN

	Condition	YES	NO	Do Not Know
1.	New or Changing moles/skin lesions			
2.	Birthmarks			
3.	New rashes			
4.	Sensitivity to the sun			
5.	Itching			
6.	Burning			
7.	Non-healing skin wounds/ulcers			
8.	Dry skin			
9.	Flaky scalp/dandruff			

HEAD, EYES, EARS, NOSE THROAT

	Condition	YES	NO	Do Not Know
1.	Headaches			
2.	Dizziness or fainting spells			
3.	Vision problems/double or blurred vision			
4.	Problems with hearing			
5.	Sinus trouble			
6.	Nosebleeds			
7.	Sores on tongue or inside mouth			
8.	Bleeding gums			
9.	Unusual trouble with teeth			
10.	Recent cold or sore throat			
11.	Itchy eyes, nose, or throat (Hay fever/Allergies)			
12.	Dry eyes			
13.	Dry mouth			

ENDOCRINE

	Condition	YES	NO	Do Not Know
1.	Thyroid problems			
2.	Heat intolerance			
3.	Cold intolerance			
4.	Changes in hair			
5.	Changes in nails			
6.	Changes in skin texture			
7.	Bone disorders			
8.	Diabetes			

HEART

	Condition	YES	NO	Do Not Know
1.	Heart problems			
2.	Bruise easily or bleed easily/Bleeding problems			
3.	High blood pressure			
4.	Pressure in chest			
5.	Undue shortness in breath (day or night)			
6.	Ankle Swelling/Edema			
7.	Pain in legs while walking			
8.	Have you ever had a blood transfusion			
9.	Implanted device (Shunt, pump, pacemaker)			

PULMONARY

	Condition	YES	NO	Do Not Know
1.	Chronic cough, coughed up blood			
2.	Do you have the date of your last chest x-ray?			
3.	Soaking sweats			
4.	Exposure to TB (tuberculosis)			
5.	History of a positive TB test (+PPD)?			
6.	Asthma			
7.	Lung disease			

GASTROINTESTINAL

	Condition	YES	NO	Do Not Know
1.	Abdominal pain			
2.	Difficulty swallowing			
3.	Nausea or vomiting			

	Condition	YES	NO	Do Not Know
4.	Frequent bowel movements			
5.	Constipation			
6.	Recent change in bowel movements			
7.	Black bowel movements			
8.	Blood in stools			
9.	Jaundice			
10.	History of hepatitis?			
11.	Sensitivity to Gluten?			
12.	History of inflammatory bowel disease?			

GENITOURINARY URINARY

	Condition	YES	NO	Do Not Know
1.	Kidney problems			
2.	Blood in urine			
3.	Testicular pain/tenderness			

MUSCOLOSKELETAL/IMMUNE

	Condition	YES	NO	Do Not Know
1.	Joint pain/arthritis			
2.	Back or bone pain			
3.	Numbness or tingling of hands or feet			
4.	Muscle pain or weakness, sore muscles			
5.	Muscle spasms			
6.	History of autoimmune disease			
7.	Abnormal antibody tests?			
8.	Immune problems			
9.	Color changes in fingers/toes (white, blue or red)			
10.	Blood disease			

NEUROLOGIC

	Condition	YES	NO	Do Not Know
1.	Excessive worry			
2.	Excessive depression			
3.	Nervous disorders			
4.	Slowed thinking, decreased concentration or decreased memory (out of ordinary)			
5.	Seizures			
6.	Tremors			

	Condition	YES	NO	Do Not Know
7.	Strokes			
8.	Trans Ischemic Attack (TIA)			
9.	Changes in your vision			
10.	Problems with bowel/bladder control			
11.	Unsteady walking			
12.	Loss of balance			
13.	Headaches			
14.	Dizziness/Fatigue			
15.	Mental/behavioral health problem			

Habits

		YES	NO
1.	Alcohol intake: Indicate next to each the amount of drinks and circle Frequency – i.e. Daily, Weekly or Monthly. Beer: #_____ Daily, Weekly, Monthly Wine: #_____ Daily, Weekly, Monthly Whiskey: #_____ Daily, Weekly, Monthly Other: #_____ Daily, Weekly, Monthly		
2.	Smoking: Cigarettes #___ or packs _____ (half, 1, 2, etc) x #_____years		
3.	Intravenous Drug use? Yes _____ No _____		
4.	Other Drug use? (such as freebase cocaine) Yes _____ No _____		
5.	Exercise If yes, type and frequency? Daily, Weekly, Monthly		

Recent Travel:

Dates	Location	Unusual exposures

Certain diseases are more common in specific genetic backgrounds. Please indicate your ethnicity:

- ☐ Caucasian
- ☐ Black or African American
- ☐ Non-African Black
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Hispanic/Latino

☐ Other: _____

Past Surgeries (Operations):

Please list in chronological order

DATE	TYPE OF OPERATION	REASON FOR SURGERY	HOSPITAL	DOCTOR

Other Recent or Pertinent Hospitalizations:

Please list in chronological order

DATE	TYPE	HOSPITAL	DOCTOR

Please list any medications/herbs/supplements you are taking, date that you started and the date you discontinued (if applicable).

Pain Pills:
Tranquilizers:
Sleeping Pills:
Antibiotics (recently):
High blood pressure medicine/water pills:
Medicine for cholesterol control:
Over the counter/non-prescription drugs/nutritional supplements (i.e. Aspirin, Tylenol, Motrin, Aleve, Vitamins, Diet Pills, herbs, etc.):
Other medications:

Family History:

RELATION	AGE	STATE OF HEALTH	IF DECEASED – CAUSE OF DEATH	AGE AT DEATH
Father				

Mother				
Brothers				
Sisters				
Children				

Have any of your *blood* relatives, husband, wife or children had any of the following?

YES	NO	(CHECK EACH ITEM)	RELATION(S)
		Tuberculosis	
		Diabetes	
		Cancer (Melanoma, Basal cell, Squamous cells, Merkel or other)	
		Autoimmune disease (Lupus, Dermatomyositis, Vitiligo, Pemphigus, Pemphigoid, Scleroderma)	
		Unusual moles (Atypical Nevus Syndrome, Giant Congenital Nevus)	
		Kidney Disease	
		Asthma, Hay Fever, Other Allergy	
		Chronic Arthritis (Rheumatism)	
		Multiple Sclerosis or Guillan Barre Syndreom	
		Nervous Or Mental Disorder	
		Any Other Illness (please specify):	

Fitzpatrick Skin-Type
Genetic Disposition

Score	0	1	2	3	4
What is the color of your eyes?	Light blue, Grey, Green	Blue, Grey or Green	Blue	Dark Brown	Brownish Black
What is the natural color of	Sandy Red	Blond	Chestnut/ Dark Blond	Dark Brown	Black

your hair?					
What is the color of your skin (non sun-exposed areas)?	Reddish	Very Pale	Pale with Beige tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	none

Reaction to Sun Exposure

Score	0	1	2	3	4
What happens when you stay in the sun too long with no sunscreen?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rare burns	Never had burns
To what degree does your skin tan/brown?	Hardly or not at all	Light colour tan	Reasonable tan	Tan very easy	Turn dark brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem