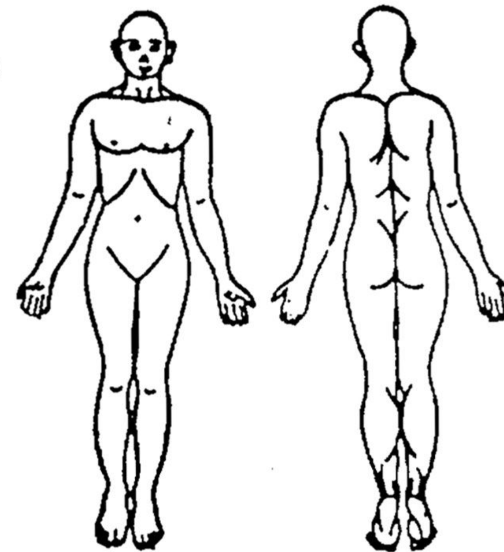
DeBlieck Dermatology

Jan DeBlieck MD
Physician & Surgeon

Medical History Questionnaire (please print)

Name:____
Occupation:____________________________________
Birthdate:_____________________________________
Age:____
Referring Physician:______________________________

- What is your skin problem? (Rash, Growths, Warts, Etc.)
____
- When did you first notice this problem?
____
- Please **DRAW** on this chart where your present skin problem or rash is, by marking X's on the figure...



	YES	NO
Has a doctor given you anything for this skin condition? If yes, please give names of **EVERYTHING** used.	❑	❑
Have you put anything else on the skin yourself? If yes, please give names of **EVERYTHING** used.	❑	❑
Have you had any other skin problems? If yes please list.	❑	❑
What have you treated these problems with?		
Does anyone in your family have skin problems or rashes?	❑	❑
Does anything **TOUCHING** your skin cause a rash or allergy? (jewelry, Poison Oak, etc.) If yes, please list.	❑	❑

- When exposed to the sun, do you:
❑ Always Burn ❑ Sometimes Burn ❑ Rarely Burn ❑ Always Tan

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Condition	Yes	No
Heart disease	❑Yes	❑No
Angina or heart attack	❑Yes	❑No
Heart rhythm abnormality	❑Yes	❑No
Heart murmur	❑Yes	❑No
Mitral valve prolapse	❑Yes	❑No
Pacemaker	❑Yes	❑No
Artificial heart valve(s)	❑Yes	❑No
Artificial joint(s)(e.g. hip, knee)	❑Yes	❑No
Antibiotics before undergoing dental or surgical procedures	❑Yes	❑No
High blood pressure	❑Yes	❑No
Lung disease	❑Yes	❑No
Breathing difficulty	❑Yes	❑No
Ulcers (stomach)	❑Yes	❑No
Kidney disease	❑Yes	❑No
Diabetes	❑Yes	❑No
Glaucoma	❑Yes	❑No
Liver disease	❑Yes	❑No
Hepatitis or yellow jaundice	❑Yes	❑No
Blood transfusions	❑Yes	❑No
AIDS or HIV positive	❑Yes	❑No
Thyroid disease	❑Yes	❑No
Emotional disorder	❑Yes	❑No
Fainting spells or dizziness	❑Yes	❑No
Seizures	❑Yes	❑No
Arthritis	❑Yes	❑No
Lupus/Dermatomyositis	❑Yes	❑No
Anemia	❑Yes	❑No
Bleeding disorder or tendency	❑Yes	❑No
Excessive scarring or keloids	❑Yes	❑No
Problems with healing	❑Yes	❑No
Surgical wound infection	❑Yes	❑No
Cold sores or fever blisters	❑Yes	❑No
X-ray treatment to your skin	❑Yes	❑No

(OVER, PLEASE)

HAVE YOU OR ANY OF YOUR FAMILY HAD:

	YOU		FAMILY		
Asthma	☐Yes	☐No	☐Yes	☐No	
Hay Fever	☐Yes	☐No	☐Yes	☐No	
Allergies	☐Yes	☐No	☐Yes	☐No	
Eczema	☐Yes	☐No	☐Yes	☐No	
Hives	☐Yes	☐No	☐Yes	☐No	
Hemophilia	☐Yes	☐No	☐Yes	☐No	
Skin cancer	☐Yes	☐No	☐Yes	☐No	If yes, whom:________________
Melanoma	☐Yes	☐No	☐Yes	☐No	If yes, whom:________________

- Are you pregnant? ☐N/A ☐Yes ☐No
  If yes, estimated due date________________
- Are you planning on becoming pregnant in the near future?
  ☐N/A ☐Yes ☐No
- Are you breast feeding? ☐N/A ☐Yes ☐No
- Do you use birth control? ☐Yes ☐No
  If yes, which method________________
- Do you smoke? ☐Yes ☐No
  If yes, how much?________________For how long?________________
- Do you drink alcohol? ☐Yes ☐No
  If yes, how much?________________

- Please list all medical problems/illnesses:
  ____
  ____
  ____
  ____
- Please list all surgeries:
  ____
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  ____
- Are you allergic to any medications? ☐Yes ☐No
  If so, please list:________________
- Have you experienced any adverse reaction to local anesthetic?
  If yes, please describe:________________
- Please list *all* medications:
  - Prescription medications, both oral and topical
  - "Over-the-counter" medications, including herbal preparations
  - Those taken regularly and those taken on an as needed basis

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Signature:________________ Date:________________