

Medical Records Number

Mountainview Skin Care, PC
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Health Questionnaire

Name: _____ Date of Birth: _____ Date: _____

Referring Physician: _____ Previous Dermatologist: _____

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS:

1. What problem(s) or concern(s) brings you to the Dermatologist today? _____

2. How long has this problem(s) been present? _____
3. Describe any symptoms in the affected area:

4. Have you tried any medication or treatment for this problem? Yes No
If yes, please list and indicate whether a specific treatment was helpful.

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE OR HAVE HAD:

- | | | |
|------------------------|--------------------------|-------------------------|
| Anemia | Congestive Heart Failure | Kidney Disease |
| Angina | Diabetes | Liver Disease/Hepatitis |
| Anxiety/Depression | Emphysema (COPD) | Organ Transplant |
| Arrhythmias | GI Disorders | Pacemaker |
| Arterial Graft | Glaucoma | Prostate Enlargement |
| Arthritis | Heart Attack | Radiation Treatment |
| Artificial Heart Valve | Heart Murmur | Rheumatic Fever |
| Artificial Joint(s) | Heart Surgery | Skin Disease |
| Asthma/Bronchitis | High Blood Pressure | Stroke/ TIA |
| Bleeding Disorder | Immune System Problems | Sun Sensitivity |
| Cancer | Infections (HIV/TB) | Thyroid Disease |
| Cancer (Skin*) | | |

Other: _____

* If you have had a skin cancer, what type? _____

List previous illnesses and operations: _____

