BAHR DERMATOLOGY HEALTH HISTORY QUESTIONNAIRE

Patient name: _____ **Date:** _____

Were you referred to us? ☐ Yes ☐ No If **YES**, by whom?_____
Who is your primary physician?_____
What is your favorite music? _____
What is your preferred pharmacy?_____
Height: _____ Weight: _____
Have you ever had skin cancer? ☐ Yes ☐ No If **YES**, which type: Basal Cell/Squamous Cell/Melanoma/Other
What year? _____ How was it treated?: _____
Family History of Melanoma? ☐ Yes ☐ No If **YES,** which family member: _____
Have you had your flu (influenza) vaccine this year (March 1, 2023-Oct 31, 2023)? ☐ Yes ☐ No
If **NO,** Why not? (allergy, don't want it, etc)_____
We recommend you get one each flu season, from your Primary care provider or pharmacy. Patient initials: _____
For those over age 65: Have you **EVER** had your pneumonia vaccine? ☐ Yes ☐ No. We recommend this too, please ask your primary care provider about possibly getting one if you have not yet. Patient initials:_____
Do you have a health care proxy in the event you are unable to make your own medical decisions? ☐ Yes ☐ No
Do you have a living will? ☐ Yes ☐ No

Skin Disease History: (please circle below all that apply)

NONE	Eczema	Precancerous Moles
Acne	Hay Fever/ Allergies	Psoriasis
Blistering Sunburns	Itchy Scalp	Tanning Bed Use (Current or Previous)
Dry Skin	Precancers	

Do you wear sunscreen? ☐ Yes ☐ No If **YES**, what SPF?_____

Past Medical History: (please circle all that apply)

NONE			
Anxiety	Depression	Stroke	Lymphoma
Asthma	Diabetes	Breast Cancer	Prostate Cancer
Atrial Fibrillation	Kidney Disease	Colon Cancer	Other Cancers
Bone Marrow Transplant	Hepatitis B or C	Leukemia	
Coronary Artery Disease	HIV/ AIDS	Lung Cancer	

Past Surgical History: (please circle all that apply)

NONE		
Mastectomy (R, L, Both)	Heart Transplant	Prostate Removed
Colon Removed	Heart Valve Replacement	Spleen Removed
Colostomy	Liver Transplant	Testicles Removed (R, L, Both)
Ovaries Removed	Lung Transplant	Tubal Ligation
Gallbladder Removed	Kidney Transplant	Hysterectomy
Coronary Artery Bypass/ Angioplasty	Pancreas Removed	Hip/Knee Replacement(s)

Other_____

Medications: (If this space is too small, please give us a list all your medications, dose, and how often you take them)

Name of medication	**Dose**	**Frequency**	**Route (i.e. by mouth, injection, etc)**

Allergies: (Please list all allergies, including drug allergies and reactions—give us a list if the space is too small)

_____
_____
_____
_____

Please answer the following questions about your health habits.

Do you drink alcohol? ☐ Yes ☐ No
How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? _____
Have you ever been a smoker of tobacco/chew tobacco? ☐ Yes ☐ No
If **YES**, when did you start using tobacco? Approx. date: _____
If you have quit using tobacco, when did you quit using tobacco? Approx. date: _____
Number of packs per day? _____
Total years using tobacco? _____

Please fill out the other side →

Review of Systems: Have you experienced any of the following within the last 10 days?

Problems with bleeding	☐ Yes	☐ No
Problems with scarring (hypertrophic or keloids)	☐ Yes	☐ No
Rash	☐ Yes	☐ No
Hay fever	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Fever or chills	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Unintentional weight loss	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Blurry vision	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No
Bloody stool	☐ Yes	☐ No
Bloody urine	☐ Yes	☐ No
Joint aches	☐ Yes	☐ No
Muscle weakness	☐ Yes	☐ No
Neck stiffness	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Depression	☐ Yes	☐ No

Do you have any of the following? (Please circle all that apply)

Allergy to Adhesive
Allergy to Lidocaine
Allergy to Topical Antibiotics
Artificial Heart Valve
MRSA history
Blood thinner medication
Defibrillator
Pacemaker
I require antibiotics prior to surgeries
I get a rapid heartbeat with epinephrine

Females only:
I am pregnant
I am currently trying to get pregnant
I am breastfeeding

PLEASE PRESENT THIS FORM WITH YOUR INSURANCE CARD AND PHOTO ID TO THE RECEPTIONIST

Revised 01/04/2023