Dermatology Clinic Health History Questionnaire

Name ___________________________________________________________   Date_____________
Date of Birth _____________   E-mail____________________________________________________

Welcome to the UW Dermatology Center. We are very pleased you chose us for your care. Thank you.

FOLLOW-UP: When we contact you about results related to your visit is a detailed phone message ok?

□ Yes  □ No       If yes, preferred number_______________________________

Chief Complaint - Please describe the problem that brings you into the office today:

<table>
<thead>
<tr>
<th>Allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have any allergies? □ Yes  □ No       If so, please list</td>
</tr>
<tr>
<td>To Medications? ________________________________</td>
</tr>
<tr>
<td>To Foods? ________________________________</td>
</tr>
<tr>
<td>2. Are you allergic to latex? □ Yes  □ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please list any prescription drugs you are taking?</td>
</tr>
<tr>
<td>Medications</td>
</tr>
<tr>
<td>__________________</td>
</tr>
<tr>
<td>__________________</td>
</tr>
<tr>
<td>__________________</td>
</tr>
<tr>
<td>__________________</td>
</tr>
<tr>
<td>__________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Over-the-Counter Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ None</td>
</tr>
<tr>
<td>__________________         _____________         ______________          ___________________________</td>
</tr>
<tr>
<td>__________________         _____________         ______________          ___________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Herbs, Vitamins, Minerals, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ None</td>
</tr>
<tr>
<td>__________________         _____________         ______________          ___________________________</td>
</tr>
</tbody>
</table>

Pharmacy Name:________________________________ Phone #________________________________

UW Medicine
Harborview Medical Center – University of Washington Medical Center
UW Medicine Primary Care – Valley Medical Center – UW Physicians

DERMATOLOGY CLINIC HEALTH HISTORY QUESTIONNAIRE
Page 1 of 2
### Social History

Occupation___________________________ Where did you grow up? _______________________________

Who do you live with? (check all that apply)  □ I live alone □ Spouse/Partner □ Children □ Parents □ Other

Do you have pets?  □ Yes □ No

### Habits and Risk Factors

#### Tobacco Use
- □ Never
- □ Past
- □ Current
- □ Passive

#### Marijuana Use
- □ Never
- □ Past
- □ Current

Types:  □ Smoking
□ Vaping
□ Edibles
□ Topicals

#### Alcohol Use
- □ Never
- □ Past
- □ Current

Drinks per week _______________

#### Other Drug Use
- □ Never
- □ Past
- □ Current

Types:  □ Amphetamines/Meth
□ Cocaine
□ Benzodiazepines
□ Opioids
□ Hallucinogens
□ Anabolic Steroids

---

### SKIN HISTORY

□ □ Have YOU had skin cancer?
- □ Basal cell carcinoma
- □ Squamous cell carcinoma
- □ Melanoma
- □ unknown

□ □ Family history of skin cancer
 If yes, who? (mother, sister, son, etc.) __________________________
- □ Basal cell carcinoma
- □ Squamous cell carcinoma
- □ Melanoma
- □ unknown

□ □ History of serious sunburn(s)

□ □ History of tanning beds, Ultraviolet lights

□ □ Do you use sunscreen regularly?

□ □ Do you wear hats in the sun?

□ □ History of ionizing radiation

□ □ History of asthma

□ □ History of eczema

□ □ History of seasonal allergies

---

### HEALTH HISTORY:

Have you had any of the following:

Yes □ No □

□ Organ or stem cell transplant

□ Cancer (type) _______________

□ Heart murmur

□ High blood pressure

□ Liver disease, jaundice, hepatitis

□ Depression or other mental illness

□ Artificial joints or heart valves

□ Do you take antibiotics when you go to the dentist?

□ Diabetes

□ Tuberculosis (TB)

□ Uncontrolled bleeding

□ Stroke

□ Blood clot

□ HIV

□ Raynaud’s (problems with your fingers when you go out in the cold)

□ Thyroid disease

□ Sexually transmitted infection