INTEGRATED DERMATOLOGY OF RESTON

Morgana Colombo, MD

HEALTH QUESTIONNAIRE

Date: _____

Name: _____ Age: _____ Date of Birth: _____

Referred By: _____

Primary Care Physician: _____ Phone: _____

Primary Reason for Your Visit: _____

_____

Duration of Problem: _____

Treatment: _____

Aggravating Factors: _____

Current Medications (please include over-the-counter, herbs, vitamins, supplements): _____

_____

_____

Allergies to Medication: ☐None ☐ _____

Other Allergies: ☐None ☐Latex ☐Bandages/Adhesive

☐Topical Antibiotic (Neosporin or other) _____

Have you ever had a bad reaction to local anesthesia? ☐No ☐Yes ☐Never had anesthesia

FOR WOMEN ONLY:

Are you currently pregnant, trying to become pregnant, or are you nursing? _____

Are you on a contraceptive, and if so, what form? _____

SKIN CONDITIONS:

Have you ever had skin cancer? ☐No ☐Yes

If Yes, ☐Basal Cell Cancer ☐Squamous Cell Cancer ☐Melanoma

Where? _____ When? _____

Treatment? _____

Has anyone in your family ever had skin cancer? ☐No ☐Yes

If Yes, ☐Basal Cell Cancer ☐Squamous Cell Cancer ☐Melanoma

Who? _____

1886 Metro Center Drive, Ste. 650 Reston, VA 20190 Phone (703) 437-7744 • Fax (703) 435-3951

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Do you have any history of skin problems or diseases? ☐No ☐Yes

If Yes, ☐Psoriasis ☐Eczema ☐Keloid ☐Other _____

SUN EXPOSURE:

When you are exposed to the sun do you:

☐ always burn
☐ usually burn, tan minimally
☐ sometimes mild burn, tan uniformly
☐ rarely burn, always tan well
☐ very rarely burn, tan very easily
☐ never burn, tan very easily

Where did you grow up? _____

Did you: ☐ sunburn every summer in childhood
☐ get at least one blistering sunburn, how many _____
☐ ever use a tanning bed, how many times/how often _____

Do you: ☐ Use sunscreen regularly, SPF _____

PAST SURGERIES (Type and Date): _____

_____

_____

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS:

Allergic/Immunologic: ☐Normal ☐Seasonal allergies ☐Immunosuppression ☐Autoimmune problem

Constitutional: ☐Normal ☐Weight loss/weight gain ☐Fever/Night sweats ☐Fainting

Cancer: Type _____

Cardiovascular: ☐Normal ☐Artificial Heart Valve ☐Pacemaker ☐Implanted Defibrillator ☐Irregular Heartbeat ☐Chest Pain/Heart attack ☐Mitral Valve Prolapse ☐Other _____

Ears/Eyes/Nose: ☐Normal ☐Glaucoma ☐Glasses/Contacts ☐Other _____

Endocrine: ☐Normal ☐Diabetes ☐Thyroid Disease ☐Other _____

Gastrointestinal: ☐Normal ☐Reflux ☐Liver Problem ☐Nausea ☐Diarrhea ☐Other _____

Genital/Urinary: ☐Normal ☐Enlarged Prostate ☐Prostate Cancer

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Hematologic: ☐Normal ☐Anemia ☐Bleeding Problems ☐Other _____

Infections: ☐Normal ☐HIV ☐Hepatitis ☐Tuberculosis/+PPD Skin Test

☐Other _____

Musculoskeletal: ☐Normal ☐Arthritis ☐Artificial Joint ☐Other _____

Neurological: ☐Normal ☐Stroke ☐Seizures/Epilepsy ☐Multiple Sclerosis

☐Other _____

Respiratory: ☐Normal ☐Asthma ☐Emphysema ☐Other _____

Psychiatric: ☐Normal ☐Depression ☐Anxiety Attacks ☐Other _____

Others: ☐Kidney Problems ☐Cold Sores ☐Varicose Veins

☐Require Antibiotics Prior to Dentistry

Any other medical problems: _____

FAMILY HISTORY: ☐Eczema ☐Psoriasis ☐Other _____

COSMETIC HISTORY: ☐BOTOX Injectable Fillers ☐Laser Treatments

SOCIAL HISTORY:

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow/Widower

Occupation:

_____

Smoking: ☐No ☐Former ☐Yes, packs/day _____

Alcohol: ☐No ☐Yes, how much/often _____

By signing, I am acknowledging that I have disclosed all of my health information known to me at this time, and all of my other personal information is accurate. I understand that it is my obligation and responsibility to notify Integrated Dermatology of Reston, LLC of any changes in my medical information during the course of my medical treatment.

❖SIGNATURE_____ Date _____

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