LAURA WAGNER, INC. **Health Questionnaire** **Visit Date:** _____

PATIENT NAME: _____ **DOB:** _____

REASON FOR TODAY'S VISIT: _____

Answer all questions that you can. For your privacy, if you need help, tell the nurse when she takes you back to a room.

PERSONAL HISTORY OF SKIN CANCER: check all that apply

☐ Melanoma ☐ Squamous Cell Carcinoma ☐ Basal Cell Carcinoma ☐ Actinic Keratosis (pre-cancers)

MEDICATIONS and ALLERGIES:

MEDICATIONS: Do you currently take any prescription medications? ☐ Yes ☐ No

☐ I'm not sure about my medications. (Don't worry. The nurse may be able to pull up a list on-line.)

☐ I have provided a separate list of my medications. ☐ I have listed my medications here.

_____

_____

Do you have any DRUG ALLERGIES? ☐ Yes ☐ No *List prescription names & your reaction to the drug.*

_____

_____

OTHER ALLERGIES: ☐ Latex ☐ Tape ☐ Band-aids ☐ List Other:

PATIENT SURGICAL HISTORY: check all that apply

☐ Skin Cancer Surgery **Females only** check those that apply: ☐ Hysterectomy ☐ Tubal Ligation ☐ Sterilization

FAMILY HISTORY OF SKIN CANCER: check & circle all that apply.

☐ No Known Family History

☐ Melanoma *RELATIONSHIP TO YOU:* MOTHER * FATHER * SIBLING * CHILD

☐ Squamous Cell Carcinoma *RELATIONSHIP TO YOU:* MOTHER * FATHER * SIBLING * CHILD

☐ Basal Cell Carcinoma *RELATIONSHIP TO YOU:* MOTHER * FATHER * SIBLING * CHILD

☐ Skin Cancer… type is unknown *RELATIONSHIP TO YOU:* MOTHER * FATHER * SIBLING * CHILD

PATIENT SOCIAL HISTORY:

Smoking Status: ☐ Current Smoker ☐ Never Smoker ☐ Former Smoker

Females only check one:: ☐ Pregnant ☐ Nursing ☐ Trying to conceive ☐ None of these

IMMUNIZATIONS:

Have you had the FLU SHOT this season? *The flu season is October – March.*

☐ **YES**/approximate date: _____ ☐ **NO/circle one:** not yet * declined * allergy to vaccine * other: _____

Have you ever had the PNEUMONIA SHOT?

☐ **YES**/approximate date: _____ ☐ **NO/circle one:** not yet * declined * allergy to vaccine * other: _____

PATIENT MEDICAL HISTORY: Have you been diagnosed or treated for any of the following? ☐ **Yes** ☐ **No** Check all that apply.

☐ AIDS/HIV	☐ DEFIBRILLATOR	☐ HYPERTENSION	☐ STROKE
☐ ARTHRITIS	☐ DIABETES	☐ KIDNEY DISEASE	☐ THYROID PROBLEMS
☐ ARTIFICIAL HEART VALVE	☐ EMPHYSEMA	☐ LIVER DISEASE	☐ TUBERCULOSIS
☐ ARTIFICIAL JOINT	☐ G.E.R.D.	☐ MIGRAINES	
☐ ASTHMA	☐ GLAUCOMA	☐ ORGAN TRANSPLANT	
☐ BLOOD THINNERS	☐ HEART DISEASE	☐ OTHER CONDITION: please list	
☐ CANCER other than skin-**Type:**	☐ HEPATITIS: A * B * C	☐ PACEMAKER	
☐ CHEMOTHERAPY	☐ HERPES SIMPLEX VIRUS	☐ RADIATION THERAPY	
☐ COLITIS	☐ HIGH CHOLESTEROL	☐ SEIZURES	