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

PATIENT NAME: _____ **DOB:** _____

REASON FOR TODAY'S VISIT: _____

PATIENT PERSONAL HISTORY OF SKIN CANCER: check all that apply

☐ No personal history of Skin Cancer ☐ Skin Cancer… type unknown ☐ I don't know

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

Who did your skin cancer surgery or treatment?

MEDICATIONS and ALLERGIES:

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

☐ I have listed my meds on this form ☐ I have provided a separate list of my meds

☐ I'm not sure about my meds (It's ok. The nurse can download your meds from the Pharmacy hub)

_____

_____

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? *Flu season is between October& March.*

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

Have you ever had the PNEUMONIA SHOT? *Answer this question regardless of the date.*

☐ **YES**/approximate date: _____ ☐ **NO (circle reason):** 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	☐ DIABETES	☐ HYPERTENSION	☐ STROKE
☐ ARTHRITIS	☐ EMPHYSEMA	☐ KIDNEY DISEASE	☐ THYROID PROBLEMS
☐ ARTIFICIAL HEART VALVE	☐ G.E.R.D.	☐ LIVER DISEASE	☐ TUBERCULOSIS
☐ ARTIFICIAL JOINT	☐ GLAUCOMA	☐ MIGRAINES	
☐ ASTHMA	☐ HEART DISEASE	☐ ORGAN TRANSPLANT	
☐ BLOOD THINNERS	☐ HEPATITIS: A * B * C	☐ OTHER CONDITION: please list:	
☐ CANCER other than skin-Please note the **Type** of cancer:			
☐ CHEMOTHERAPY	☐ HERPES SIMPLEX VIRUS	☐ RADIATION THERAPY	
☐ COLITIS	☐ HIGH CHOLESTEROL	☐ SEIZURES	

CHECK ALL THAT APPLY YOU: ☐ **I HAVE A DEFIBRILLATOR** ☐ **I HAVE A PACEMAKER** ☐ **NONE**