

Columbia Presbyterian Medical Center
Department of Dermatology
New York Presbyterian Hospital
Tel: 212-305-3625

Unit for Dermatologic Surgery and Cutaneous Oncology
Mohs Micrographic Surgery
Laser Surgery
Cosmetic Dermatologic Surgery

Desiree Ratner, M.D., Director
Monica Halem, M.D.

Health Questionnaire

Name: _____

Telephone: (Home) _____ (Work) _____

Age: _____ Occupation: _____

Referring Physician: _____

Physician Primary: _____

Do you have or have you ever had any of the following conditions:

	Circle one			Circle one	
Bleeding disorder	Yes	No	Gastrointestinal disease	Yes	No
Cancer (other than skin cancer)	Yes	No	Yellow Jaundice	Yes	No
Migraine headaches	Yes	No	Diabetes mellitus	Yes	No
Epilepsy	Yes	No	Artificial heart valve	Yes	No
Glaucoma	Yes	No	Artificial joint	Yes	No
Heart attack	Yes	No	Pacemaker	Yes	No
Other heart disease	Yes	No	Implanted defibrillator	Yes	No
High Blood Pressure	Yes	No	Chronic infectious disease	Yes	No
Asthma or other lung disease	Yes	No	Stroke / TIA'S	Yes	No
Kidney Disease	Yes	No			
Rheumatic Fever	Yes	No			
Any other medical problems (if yes, please explain)	_____				

Health Questionnaire

Do you smoke? _____ If so, how much? _____

Do you drink alcohol? _____ If so, how much? _____

Have you ever been told that you should take prophylactic antibiotics for dental surgery?

Have you experienced any allergies to medication? (Please list the medication and reaction you experienced? _____

Please list all medications or drugs you are taking at the present time.

Medication & Dosage

How Often

Do you take?

Aspirin? Yes / No

Motrin, Ibuprofen, Naprosyn? Yes / No

Coumadin? Yes / No

Other blood thinning medications? (If yes please name medication)

Please list any major surgeries and/or hospitalizations you have had _____

If applicable:

Where is your area of concern/skin cancer located? _____

Does it itch? Yes / No

Has it bled? Yes / No

Is it painful? Yes / No

Health Questionnaire

When did you first notice this condition? _____

Do you have any history of X-ray treatment? Yes / No

Do you have any history of ultraviolet light treatment? Yes / No

Has your skin cancer been treated by a physician in the past? Yes / No

If yes what type of treatment and date? _____

Do you have a family history of skin cancer Yes / No

If so, what kind of skin cancer? _____

What other medical problems run in your family? _____

Which relatives are in affected? _____

Patient Signature

Date

Review of systems

Patient Name: _____

Constitutional Systems	Y	N	Genito-Urinary	Y	N
Fever	_____	_____	Urinary Frequency	_____	_____
Weight loss or gain	_____	_____	Urinary pain or blood	_____	_____
Fatigue	_____	_____	Males		
			Discharge, lesions or masses	_____	_____
Skin			Female		
Rashes or color changes	_____	_____	Currently pregnant	_____	_____
Itching or dryness	_____	_____	Breast masses or discharge	_____	_____
Hair or nail changes	_____	_____	Vaginal bleeding/discharge	_____	_____
Eyes			Musculoskeletal		
Loss of vision	_____	_____	Joint pain, swelling, redness	_____	_____
Distorted vision or haloes	_____	_____	Muscle pain or cramps	_____	_____
Fluctuating vision	_____	_____			
Eye pain or soreness	_____	_____	Neurological		
			Headaches	_____	_____
Ears, nose, mouth, throat			Numbness or tingling	_____	_____
Hearing difficulty	_____	_____	Weakness or paralysis	_____	_____
Ringing or dizziness	_____	_____	Fainting or blackouts	_____	_____
Sinus Congestion	_____	_____	Slurred speech	_____	_____
Runny nose or post nasal drip	_____	_____			
Nosebleeds	_____	_____	Psychiatric		
Dryness/hoarseness	_____	_____	Anxiety	_____	_____
			Depression	_____	_____
Cardiovascular			Other	_____	_____
Chest pain or palpitations	_____	_____			
Other _____	_____	_____	Hematological/Lymphatics/ Immunology		
			Easy bruising/bleeding	_____	_____
Respiratory			Blood transfusions	_____	_____
Cough	_____	_____	Swollen lymph nodes	_____	_____
Shortness of breath	_____	_____			
Wheezing	_____	_____	Other symptoms not listed above:		

Endocrine			_____		
Excessive thirst or hunger	_____	_____	_____		
Heat or cold intolerance	_____	_____	_____		

Gastrointestinal					
Swallowing difficulty	_____	_____	Date: _____		
Vomiting/heartburn	_____	_____	Reviewed By: _____		