Brenda LaTowsky, MD

MEDICAL QUESTIONAIRE

*VERIFY PHARMACY (For office use only)

MEDICAL HISTORY (Please Check all that Apply

❑ Anxiety	❑ Diabetes	❑ Lung Cancer What year?________
❑ Arthritis	❑ End Stage Renal Disease	❑ Lymphoma
❑ Asthma	❑ GERD (Acid Reflux/ Heart Burn)	❑ Prostate Cancer What year?________
❑ Atrial Fibrillation (Irregular Heart Beat)	❑ Hearing Loss	❑ Radiation Treatment What year?_____
❑ BPH (Enlarged Prostate)	❑ Hepatitis (Specify Type)________________	❑ Seizures
❑ Bone Marrow Transplant	❑ Hypertension (High Blood Pressure)	❑ Stroke What year?________
❑ Breast Cancer What year?________	❑ HIV/AIDS	❑ Other___________________________
❑ Colon Cancer What year?________	❑ Hypercholesterolemia (High Cholesterol)	___________________________
❑ COPD (Lung Disease)	❑ Hyperthyroidism (Overactive Thyroid)	___________________________
❑ Coronary Artery Disease (Heart Disease/Attack)	❑ Hypothyroidism (Underactive Thyroid)	
❑ Depression	❑ Leukemia	

SURGICAL HISTORY (Please Check All that Apply & List YEAR in Space Provided)

❑ Appendix Removed ______	❑ Kidney Biopsy ______
❑ Bladder Removed ______	❑ Kidney Removed (Right or Left) ______
❑ Breast: Mastectomy (Right/Left/Both) ______	❑ Kidney Stone Removal ______
❑ Breast: Lumpectomy (Right/Left/Both) ______	❑ Kidney Transplant ______
❑ Breast Biopsy (Right/Left/Both) ______	❑ Ovaries Removed (Endometriosis) ______
❑ Breast Reduction ______	❑ Ovaries Removed (Cyst) ______
❑ Breast Implants ______	❑ Ovaries Removed (Ovarian Cancer) ______
❑ Colon Removed (Colon Cancer Resection) ______	❑ Prostate Removed (Prostate Cancer) ______
❑ Colon Removed (Diverticulitis) ______	❑ Prostate Biopsy ______
❑ Colon Removed (IBD) ______	❑ Prostate Removed (TURP) ______
❑ Gallbladder Removed ______	❑ Skin: Skin Biopsy ______
❑ Heart: Coronary Artery Bypass Surgery ______	❑ Skin: Basal Cell Carcinoma ______
❑ Heart: PTCA ______	❑ Skin: Squamous Cell Carcinoma ______
❑ Heart: Mechanical Valve Replacement ______	❑ Skin: Melanoma ______
❑ Heart: Biological Valve Replacement ______	❑ Spleen Removed ______
❑ Heart Transplant ______	❑ Testicles Removed ______
❑ Joint Replacement Knee (Right/Left/Both) ______	❑ Uterus Removed (Fibroids) ______
❑ Joint Replacement Hip (Right/Left/Both) ______	❑ Uterus Removed (Uterine Cancer) ______
❑ Other_____________________________	❑ Other_________________________________

SKIN HISTORY

❑ Acne	❑ Dry Skin	❑ Poison Ivy
❑ Actinic Keratoses (Pre-Cancers)	❑ Eczema	❑ Precancerous Moles
❑ Asthma	❑ Flaking or Itching Scalp	❑ Psoriasis
❑ Basal Cell Skin Cancer	❑ Hay Fever/Allergies	❑ Squamous Cell Skin Cancer
❑ Blistering Sunburns	❑ Melanoma	❑ Other_________________

Do you Wear Sunscreen? ❑Yes **SPF** __________ ❑No

Do you tan in a tanning salon? ❑Yes ❑No

Do you have a **Family History of Skin Cancer?** ❑Yes ❑No **If yes, who?**________________________________

If yes, what kind? ❑Melanoma ❑Basal ❑Squamous ❑Abnormal Moles

MEDICATIONS

(Please list all prescription & over-the-counter medications you are taking, including herbs, vitamins & supplements – along with the dosage)

If you currently DO NOT TAKE ANY MEDICATIONS, check this box: ❑

1) ______________________________ 4) ______________________________

2) ______________________________ 5) ______________________________

3) ______________________________ 6) ______________________________

MEDICATION ALLERGIES/REACTIONS (Please List Medication and Associated Allergic Reaction)

If you have NO KNOWN MEDICATION ALLERGIES, check this box: ❑

1) ______________________________ 3) ______________________________

2) ______________________________ 4) ______________________________

SOCIAL HISTORY:

ALCOHOL INTAKE

Do you drink alcohol? ❑NO ❑YES If so, how often? Drink(s) ________ per week.

SMOKING STATUS (Check One)

❑ Unspecified ❑ Current every day smoker ❑ Current some smoker ❑ Former smoker ❑ Never smoker ❑ Unknown

DRIVING STATUS (Check all that apply)

❑ Drives in the Daytime ❑ Drives at Night

EXERCISE

How often do you exercise? ❑ Unspecified ❑ Several times a day ❑ Once a day ❑ A few times a week

❑ A few times a month ❑ Never ❑ Other _____________

CAFFEINE USE

What is your caffeine use? ❑ Unspecified ❑ Several times a day ❑ Once a day ❑ A few times a week

❑ A few times a month ❑ Never ❑ Other _____________

CLEAR

Dermatology & Aesthetics Center

Brenda LaTowsky, MD

OCCUPATION AND WORKPLACE

Your occupation: ______________________________ Employer: ______________________________

Do you *Currently* have any of the following? (Please check all that apply)

❑ Pacemaker	❑ Allergy to Adhesives	❑ Rapid Heartbeat with Epinephrine
❑ Defibrillator	❑ Allergy to Topical Antibiotic Ointments	❑ Yeast Infections with Antibiotics
❑ Artificial Joints within Past Two Years	❑ Blood thinners	❑ GI Upset with Antibiotics
❑ Artificial Heart Valve	❑ Pregnancy or planning pregnancy	
❑ Premedication Prior to Procedures	❑ Allergy to Lidocaine	

❑ Problems with Bleeding	❑ Chest Pain	❑ Shortness of Breath
❑ Problems with Healing	❑ Cough	❑ Sore Throat
❑ Problems with Scarring	❑ Depression	❑ Thyroid Problems
❑ Immunosuppression	❑ Fever or Chills	❑ Unintentional Weight Loss
❑ Changing Mole	❑ Headaches	❑ Wheezing
❑ Rash	❑ Hay Fever	**FEMALES ONLY**
❑ Abdominal Pain	❑ Joint Aches	❑ Irregular Periods
❑ Anxiety	❑ Muscle Weakness	❑ Menopause
❑ Blood in Stool	❑ Neck Stiffness	❑ Pregnant
❑ Blood in Urine	❑ Night Sweats	❑ Trying to get Pregnant
❑ Blurry Vision	❑ Seizures	❑ Nursing/Breast Feeding