MALINSKI DERMATOLOGY

64040 HWY 434, Suite #103
Lacombe, LA 70445

New Patient Questionnaire

Name_____ Preferred Name: _____ DOB:_____ Date: _____
Weight: _____ Height:_____ Name and location of your pharmacy: _____
Reason for today's visit: _____

Your Past Medical History

Have you ever had any of the following medical problems?	YES	NO	Please give us any details
Anemia			
Asthma			
Autoimmune Disease(Lupus, Dermatomyositis, Rheumatoid Arthritis, other)			
Blood Clots			
Bleeding Disorder/prolonged bleeding after surgery			
Blood Transfusion			
Cancer (other than skin)			
Cardiac Problem			
Diabetes			
Endocrine disorder			
Gastrointestinal Disorder (GERD,stomach ulcers, Irritable Bowel Syndrome, Chron's Disease, Ulcerative Colitis, other)			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Liver Disease			
Lung Disease			
Need for antibiotic use prior to dental procedures			
Neurological Disorder (multiple sclerosis, other)			
Organ Transplant			
Pacemaker/Defibrillator			
Stroke			
Thyroid Disorder			
Psychological Disorder (anxiety, depression, other)			
Seasonal Allergies			
Tuberculosis or any other chronic infections			
Viral Infection (HIV/AIDS, Hepatitis A, B or C, CMV)			
Xray Therapy			
Other			

Your Past Surgical History (Last 10 Years)

Surgery/Hospitalization	Date	Anesthesia complications

Your Past Skin History

	Previous treatments	Treating Physician
Abnormal (Dysplastic)Mole(s)		
Acne		
Actinic Keratosis		
Allergic Contact Dermatitis		
Eczema		
Keloid Scarring/Poor Wound/Healing/Chronic Skin Ulcers		
Psoriasis		
Skin Rash in response to Medication or food		
Urticaria(Hives)		
Seborrheic Dermatitis		
Other **Skin Cancers** or Suspicious Lesions		
Other		

Your Family History

	YES	**NO**	Family member/Details
Abnormal Bleeding			
Abnormal Clotting			
Autoimmune Disorders(Lupus, Dermatomyositis, Rheumatoid Arthritis, other)			
Cancer			
Diabetes			
Eczema/Atopic Dermatitis/Asthma			
Nonmelanoma Skin Cancer(Basal Cell Carcinoma, Squamous Cell Carcinoma, other)			
Melanoma Skin Cancer			
Endocrine Disease, other(including Thyroid disorders)			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Liver Disease			
Psoriasis			
Severe Acne			
Skin Disease, other			

Your Social History

	YES	**NO**		
Do you smoke?			For how long?	Year Start:
If not, have you ever smoked?			Year Started:	Year Ended:
Do you drink?			How much?	
Do you do drugs?				
Are you exposed to dust, solvents, or other chemicals?				
Are you pregnant or is there a chance you are?				
What is your occupation?				

Please list your medications (including over -the-counter medicines, hormones, birth control pills, and herbal remedies):

_____ _____ _____

_____ _____

_____

_____

Please list any medication allergies you have and the reaction to each medication: _____

_____