



## PATIENT QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

- List all medications that you take on a regular basis:

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- Are you taking a blood thinner, like coumadin, lovenox, plavix or aspirin?  Yes  No
  - If yes, please indicate which blood thinner you take:

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- List any medications that you are allergic to:

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- Do you smoke?  Yes  No
- Do you drink alcohol?  Yes  No
- Do you use illegal drugs?  Yes  No
- Have you ever tested POSITIVE on an HIV/AIDS test?  Yes  No
- Have you ever had hepatitis, jaundice or liver disease?  Yes  No
- Would you like to receive a full body skin examination useful in detecting skin cancer?  Yes  No
- Do you have a condition that requires you to take antibiotics before surgery or dental procedures (such as mitral valve prolapse, a prosthetic hip or heart valve)?  Yes  No
  - If yes, list the condition: \_\_\_\_\_
- Do you have a pacemaker or defibrillator?  Yes  No
  - If yes, what type and what year did you receive it?  
\_\_\_\_\_
- Are you pregnant or nursing?  Yes  No
- Have **YOU** ever had SKIN cancer?  Yes  No
  - If **YES**, what type? When? \_\_\_\_\_
  - Do you have a family history of **SKIN** cancer?  Yes  No
  - If **YES**, which family member? What **TYPE**?  
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\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*