# Dallas Diagnostic Association – Plano
# Dermatology Questionnaire

Date: _____ Name: _____
Date of Birth: _____ Occupation: _____ Daytime Phone #: _____

***Did another physician refer you to this office? If so, the following information is absolutely necessary on allowing is to communicate to your referring physician about your skin condition.***

Referring Physician's Name: _____ Phone #: _____
Referring Physician's Address: _____ City: _____ State: _____ Zip: _____

**YOUR PAST MEDICAL HISTORY** (check and describe)

Previous Skin Cancer:
☐ Melanoma ☐ Squamous Cell
☐ Basal Cell ☐ Other _____

Location: _____

Surgery Performed? ☐ Yes ☐ No

Other Cancers: _____

☐ Asthma ☐ Hepatitis
☐ Seasonal Allergies ☐ HIV/Aids
☐ Others (list) _____

YOUR PAST SURGICAL HISTORY:

| Year | Type of Surgery |
|---|---|
| | |
| | |
| | |
| | |
| | |

YOUR FAMILY'S MEDICAL HISTORY — WHICH RELATIVE(S)?

☐ Melanoma _____
☐ Basal Cell Cancer _____
☐ Squamous Cell Cancer _____
☐ Seasonal Allergies _____
☐ Asthma _____
☐ Psoriasis _____
☐ Eczema/Atopic _____
☐ Others (list) _____

**YOUR SOCIAL HISTO**RY (check and answer)

Do you smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No
If yes, how often? _____

Tanning Bed Exposure? Yes ☐ No ☐
If yes, describe _____

Do you wear sunscreen? ☐ Yes ☐ No
Daily? ☐ Yes ☐ No
What SPF? ☐ 15 ☐ 30 ☐ 45 ☐ Other _____

MEDICATIONS: (Please list ALL medications you are currently taking including over the counter and herbal medications) **Note:** If your Primary Care Physician is part of DDA/Baylor you do not need to complete this section

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES TO MEDICATIONS? Yes ☐ No ☐
If yes, please list _____
_____