



Dermatology & Aesthetics Center

Brenda LaTowsky, MD

**MEDICAL QUESTIONNAIRE**

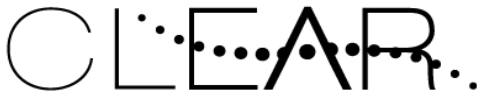
**\*VERIFY PHARMACY (For office use only)**

**MEDICAL HISTORY (Please Check all that Apply)**

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

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

- |   |   |
|---|---|
| <input type="checkbox"/> Appendix Removed _____                         | <input type="checkbox"/> Kidney Biopsy _____                      |
| <input type="checkbox"/> Bladder Removed _____                          | <input type="checkbox"/> Kidney Removed (Right or Left) _____     |
| <input type="checkbox"/> Breast: Mastectomy (Right/Left/Both) _____     | <input type="checkbox"/> Kidney Stone Removal _____               |
| <input type="checkbox"/> Breast: Lumpectomy (Right/Left/Both) _____     | <input type="checkbox"/> Kidney Transplant _____                  |
| <input type="checkbox"/> Breast Biopsy (Right/Left/Both) _____          | <input type="checkbox"/> Ovaries Removed (Endometriosis) _____    |
| <input type="checkbox"/> Breast Reduction _____                         | <input type="checkbox"/> Ovaries Removed (Cyst) _____             |
| <input type="checkbox"/> Breast Implants _____                          | <input type="checkbox"/> Ovaries Removed (Ovarian Cancer) _____   |
| <input type="checkbox"/> Colon Removed (Colon Cancer Resection) _____   | <input type="checkbox"/> Prostate Removed (Prostate Cancer) _____ |
| <input type="checkbox"/> Colon Removed (Diverticulitis) _____           | <input type="checkbox"/> Prostate Biopsy _____                    |
| <input type="checkbox"/> Colon Removed (IBD) _____                      | <input type="checkbox"/> Prostate Removed (TURP) _____            |
| <input type="checkbox"/> Gallbladder Removed _____                      | <input type="checkbox"/> Skin: Skin Biopsy _____                  |
| <input type="checkbox"/> Heart: Coronary Artery Bypass Surgery _____    | <input type="checkbox"/> Skin: Basal Cell Carcinoma _____         |
| <input type="checkbox"/> Heart: PTCA _____                              | <input type="checkbox"/> Skin: Squamous Cell Carcinoma _____      |
| <input type="checkbox"/> Heart: Mechanical Valve Replacement _____      | <input type="checkbox"/> Skin: Melanoma _____                     |
| <input type="checkbox"/> Heart: Biological Valve Replacement _____      | <input type="checkbox"/> Spleen Removed _____                     |
| <input type="checkbox"/> Heart Transplant _____                         | <input type="checkbox"/> Testicles Removed _____                  |
| <input type="checkbox"/> Joint Replacement Knee (Right/Left/Both) _____ | <input type="checkbox"/> Uterus Removed (Fibroids) _____          |
| <input type="checkbox"/> Joint Replacement Hip (Right/Left/Both) _____  | <input type="checkbox"/> Uterus Removed (Uterine Cancer) _____    |
| <input type="checkbox"/> Other _____                                    | <input type="checkbox"/> Other _____                              |



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**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 \_\_\_\_\_



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OCCUPATION AND WORKPLACE

Your occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

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

<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Allergy to Adhesives	<input type="checkbox"/> Rapid Heartbeat with Epinephrine
<input type="checkbox"/> Defibrillator	<input type="checkbox"/> Allergy to Topical Antibiotic Ointments	<input type="checkbox"/> Yeast Infections with Antibiotics
<input type="checkbox"/> Artificial Joints within Past Two Years	<input type="checkbox"/> Blood thinners	<input type="checkbox"/> GI Upset with Antibiotics
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Pregnancy or planning pregnancy	
<input type="checkbox"/> Premedication Prior to Procedures	<input type="checkbox"/> Allergy to Lidocaine	

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

OPTIONAL: I would like to schedule a cosmetic consultation with Dr. LaTowsky to discuss:

<input type="checkbox"/> Red spots	<input type="checkbox"/> Frown lines	<input type="checkbox"/> "Smokers lines"	<input type="checkbox"/> Thin lips
<input type="checkbox"/> Brown spots	<input type="checkbox"/> Forehead lines	<input type="checkbox"/> Skin texture	<input type="checkbox"/> Length/fullness of eyelashes
<input type="checkbox"/> Crow's feet	<input type="checkbox"/> Tear troughs	<input type="checkbox"/> Melasma (pregnancy mask)	<input type="checkbox"/> Overall facial appearance
<input type="checkbox"/> Other: _____			

I would like to speak with our medical aesthetician today to discuss:

<input type="checkbox"/> Under-eye cream	<input type="checkbox"/> Sunscreens	<input type="checkbox"/> Skin Care	<input type="checkbox"/> Scar revision
<input type="checkbox"/> Day cream	<input type="checkbox"/> Night cream	<input type="checkbox"/> Mineral makeup	<input type="checkbox"/> Chemical peels
<input type="checkbox"/> Other			