Carolyn B. Lyde, MD Dennis E. Newton, MD

Dermatology Center of Lewisville
324 West Main Street, Suite 200
Phone (972) 436-0358 Lewisville, Tx 75057 Fax (972) 353-3750

PATIENT MEDICAL QUESTIONNAIRE

Name____ **Age**_______ **Today's Date** _________

Reason for visit today____

*****<u>**STOP HERE IF SEEN WITHIN 3 MONTHS,**</u> ***UNLESS THERE ARE CHANGES*******

Medical Problems:

<>High Blood Pressure <>Diabetes <>Stomach Disease <>Arthritis/Joint <>Stroke <>Genital
<>Heart Disease <>Thyroid <>Bowel Disease <>Muscle <>Seizure <>Urinary tract
<>Cholesterol <>Asthma <>Liver/Hepatitis <>Lupus <>Dementia
<>Pacemaker <>Other Lung <>Kidney Disease <>Autoimmune <>Depression
<>Atrial Fibrillation <>X-Ray therapy <>Immune meds <>Other Psychiatric
<>Defibrillator <>Cancer____
<>Other not listed____

Past Non-Skin Cancer Surgeries: <>Artificial Joint <>Non-Skin Cancer Surgery <>Other______________________

Medications, supplements you currently take, <>see list____
____

Allergies to Medications____

Other Current Physicians____

Are you Pregnant or planning to become Pregnant? <>No <>Yes, Due Date _____

Skin Cancer: If we are your only skin cancer office, you may skip

<> Melanoma site________ <> Basal Cell Carcinoma site_________ <> Squamous Cell Carcinoma site_____________

Other Skin Disease: current or past____

Body Systems Review: Feeling Well in General? Yes No____________________ Check others below if they apply

<>Rash <>Fever <>Hearing <>Menstrual Irregularity <>Easy Bleed
<>Itchy Skin <>Weight Loss/Gain <>Mouth/Nose/Throat <>Genital Problem <>Blood Clot
<>Dry Skin <>Dizziness <>Vision <>Urination Problem <>Lymph Node
<>Skin Growth <>Fainting Tendency <>Eyelid Problem <>Chest Pain <>Joint Pain
<>Skin Sore <>Headaches <>Nausea/Vomiting <>Palpitations <>Muscle Pain
<>Bad Scars/Keloids <>Weak Body Part <>Abdominal Pain <>Shortness of Breath <>Leg swelling
<>Skin Color Change <>Numb Body Part <>Bowel Change <>Cough/Wheeze
<>Hair/Nail Problem <>Seizure MD Notes____

Family History:

History of Skin Disease <>Melanoma Skin Cancer <>Other Skin Cancer <>Psoriasis <>Acne <>Other___________
History of Medical Problem <>Cancer <>Heart Disease <>Other____

Social History: Occupation______________________ Hobbies_________________________ Pets________________

Change in your contact information or with whom we may speak about your condition__________________________

Smoker <>No <>If Yes, How long_________ Packs per day_______ Alcoholic drinks per week______________

Who lives in your home with you?____

MEDICAL PERSONNEL NOTES BELOW

<>new <>estab <>estab >3y	1.	2.	3.	4.
site				
duration				
symptoms				
tx				
other				

Reviewed by MD **Date**

Revised 10/3/2018