

CINDY HOFFMAN, D.O., PC; DERMATOLOGY
INITIAL VISIT QUESTIONNAIRE

Name _____ Reason for today's visit _____
Today's date _____

Are you allergic to any medications? _____ Are you currently taking any medications?
(prescription, over the counter, vitamins) list

Have you ever been treated for any of the following diagnoses or diseases:

Heart disease or pacemaker	yes	no	lung (ie. TB)	yes	no
High blood pressure	yes	no	stomach/intestinal	yes	no
Diabetes	yes	no	kidney/bladder	yes	no
Blood disorder	yes	no	liver/gall bladder	yes	no
Arthritis	yes	no	stroke/neurologic	yes	no
Emotional/psychiatric	yes	no	phlebitis	yes	no
Cancer	yes	no	eye disease	yes	no

Have you or anyone in your family had: family member

Asthma	yes	no	_____
Hay fever	yes	no	_____
Hives	yes	no	_____
Eczema	yes	no	_____
Psoriasis	yes	no	_____
Skin cancer	yes	no	_____
Melanoma	yes	no	_____
Other skin diseases	yes	no	_____

Have you ever had:

Difficulty with the healing of a wound	yes	no
Excessive bleeding when cut	yes	no
Overgrown scars or keloids	yes	no
Allergic reactions to local anesthetics	yes	no
Exposure to HIV (AIDS)	yes	no
Venereal Diseases	yes	no

Do you smoke	always	sometimes	never
Do you use a sunscreen	always	sometimes	never
When exposed to the sun do you	tan	tan and burn	burn

What soap do you use? _____ What moisturizer do you use? _____

For Women Only

Are you pregnant or planning a pregnancy	yes	no
Do you take birth control pills	yes	no

PLEASE INFORM THE DOCTOR AT ANY TIME IF YOU PLAN TO OR BECOME PREGNANT DURING YOUR TREATMENT.

Patient Signature _____ Date _____