**PARK AVENUE DERMATOLOGY (PAD) Dominick Ligresti, MD**
**Health History Questionnaire**

**Patient's Name: _____** **Date of Birth: _____** **Age:_____**
**Height: _____** **Weight:_____** **Today' Day: _____**

**Have you had any of the following conditions in the PAST and/or PRESENT:**

| Medical Conditions | Check if YES | Condition | Check if YES |
|---|---|---|---|
| Acne | | Numbness/Tingling | |
| Actinic Keratosis | | Poor Healing of Wounds | |
| AIDS | | Psoriasis | |
| Anemia | | Sarcoid | |
| Anxiety | | Seizure/Epilepsy | |
| Atrial Flutter/Fibrillation | | Skin Bruises Easily | |
| Atpical Moies | | Squarmous Cell Carcinoma | |
| Basal Cell Carcinoma | | Stroke/TIA | |
| Bleeding/Clotting disorder | | Sun sensitivity and swelling | |
| Breast lumps or masses | | Sweats | |
| Bumps under the skin | | T-Cell Lymphoma | |
| Changes in skin lesion | | Thyroid Disease | |
| Cold Sores | | Warts | |
| Dermatitis | | Weight Gain | |
| Diabetes | | Weight Loss | |
| Dry eyes | | Wheezing | |
| Dry skin | | **Other (please list)** | |
| Eczema | | | |
| Fever | | Frequency Buring | |
| Glaucoma | | Nausea, vomiting, diarrhea when taking antibiotics | |
| Hair Loss | | Yeast Infection when taking anibiotics | |
| Heart Arrhythmia | | Gastrointestinal/Stomach absortive disorder | |
| Heart Murmur | | Arthritix/Join Deformity | |
| Heart Palpitations | | Arthralgia | |
| Heat Disease | | Limited Motion | |
| Hepatitis | | Artificial Join | |
| Herpes Simplex | | Convulsions or Epilepsy | |
| Hirsutism | | | |
| HIV Infection | | | |
| Inflamed Skin | | | |
| Itching eyes | | | |
| Itchy skin | | | |
| Keloid | | | |
| Kidney Disease | | | |
| Lupus | | | |
| Melanoma | | | |
| Mitral Valve Prolapse | | | |

**Have you had any of the following Surgeries in the PAST:**

| Medical Conditions | Check if YES |
|---|---|
| Cataracts | |
| Endoscopy | |
| Heart Bypass Surgery | |
| Heart Valve Replacement | |
| Hernia Repair | |
| Join Replacement | |
| **PACEMAKER** | |
| **Other (please list)** | |
| | |
| **Personal Habits:** | |
| Do you use a tanning bed? | |
| Have you had sunburn or sunburn blisers? | |
| Do you smoke? | |
| Do you drink alcohol? | |
| Do you use drugs? | |
| | |
| **Medications:** | |
| Are you taking Coumadin? | |
| **Are you taking Aspirin?** | |
| **Are you taking Vitamin E?** | |
| | |
| **Family Medical History:** | |
| Acne | |
| Allergies (Seasonal) | |
| Atypical Moles | |
| Basal Cell Carcinoma | |
| Eczema | |
| Lupus | |
| Melanoma | |
| Psoriasis | |
| Sarcold | |
| Squmous Cell Carcinoma | |
| | |
| **Other:** | |
| Are you pregnant? | |
| Are you nursing? | |
| Do you plan on becoming pregnant? | |

List any allergies to medications: _____

Current Medications including Prescription, Over the Counter, Herbal and Vitamins:

1. _____ Dosage_____ Directions_____
2. _____ Dosage_____ Directions_____
3. _____ Dosage_____ Directions_____
4. _____ Dosage_____ Directions_____
5. _____ Dosage_____ Directions_____
6. _____ Dosage_____ Directions_____
7. _____ Dosage_____ Directions_____
8. _____ Dosage_____ Directions_____
9. _____ Dosage_____ Directions_____

Are you currently receiving any treatment for any specific skin diseases? If yes please list name of the physician and medications:

_____

_____

**Patient's Signature** **Date**