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**