Initial Visit Questionnaire

Patient's Name _____ Date_____

Any Medication allergies? If so which ones?

_____

Have you or a family member ever been treated for:

	Patient	Family		Patient	Family
High blood pressure	____	____	Stroke/Head Injury	____	____
Heart disease	____	____	Seizures	____	____
Kidney disease	____	____	Vagal fainting episodes	____	____
Lung disease	____	____	Arthritis	____	____
Tuberculosis	____	____	Thyroid problems	____	____
Immundeficiency	____	____	Diabetes	____	____
Stomach problems	____	____	Asthma	____	____
Bowel problems	____	____	Sinus allergies/infections	____	____
Cancer	____	____	**Skin Cancer**	____	____

Have you had your heart valves diseased, floppy or replaced? Yes No
Do you have a cardiac pacemaker? Yes No
Do you take aspirin or other blood thinners? Yes No
Where did you grow up? _____
Did you have sunburns as a child? Yes No
Are you active outside now? Yes No
Have you had X-ray treatment to the skin? Yes No Where?
Have you had:
Eczema Yes No
Psoriasis Yes No
Hives Yes No
Keloids/abnormal scarring Yes No
Have you had pre-skin cancers frozen? Yes No

Have you had **skin cancers:**

Where/When?

Basal cell cancer _____
Squamous cell cancer _____
Melanoma _____

Current medications (including vitamins, herbs or over the counter)?

_____ _____
_____ _____
_____ _____

Health Habits? **Caffeines** _____
(How much?) **Tobacco** _____
Alcohol _____

SASCC
San Antonio, Texas