CHERRY CREEK DERMATOLOGY, P.C.
J. Michael Maloney, M.D. F.A.A.D.
INITIAL PATIENT HEALTH QUESTIONNAIRE

Your Name_____ Do you go by a nickname?_____

Date of birth _____Primary Doctor:_____Today's Date: _____

Preferred Contact Method: Phone Email Letter (please circle one)

***PHONE NUMBER:_____**Home Work Mobile (please circle one)

****Is it ok to leave a detailed message: YES NO (please circle one)

***EMAIL ADDRESS_____**

***PREFERED PHARMACY?_____**

Please tell us why you are here_____
_____

Past Medical History: (please explain)

_____
_____
_____

Past Surgical History: (please explain)

_____
_____
_____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None
Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Skin Phototype: (Please circle one)
Always burns easily; never tans
Always burns easily; tans minimally and with difficulty
Burns minimally; tans gradually and uniformly (light brown)
Burns minimally; always tans well (moderate brown)
Rarely burns; tans profusely (dark brown)
Never burns; deeply pigmented (black), tans profusely

Medications: (Please enter all current medications)

_____
_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____
_____

*****The Federal Government has asked for us to collect this information.**

*****Ethnicity:** (Please circle one)
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White
Other Race_____

*****Race:** (Please circle one)
Hispanic or Latino
Not Hispanic or Latino
Prefer not to Specify

*****Preferred Language:** (Please circle one)
English
Other_____

*****Cigarette Smoking**: (Please circle one)
Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Do you use illicit drugs? No Yes
Do you drink alcohol? None? Less than 1? 1-2 drinks per day? 3 or more drinks per day?
Is there anything about your sexual history or sexual orientation that you think may impact your skin disease? No Yes
Are you HIV positive? No Yes
Are there any other social factors that may be relevant to your visit today?_____

Review of Systems: Are you currently experiencing any of the following?

Symptom	Yes	No
Are you feeling well?		
Recent illness or surgery, new medication?		
Allergy, asthma, hay fever?		
Heart, vascular disorder?		
Thyroid, diabetes, gland problem?		
Ear, Nose, Throat, Mouth?		
Eye, vision problems?		
Digestion or bowel problems, liver disorder?		
Prostate problems? (males)		
Post menopausal, hysterectomy, tubal ligation?		
Genital, reproductive, kidney or bladder problems?		
Blood or lymph node problems?		
Chronic rash?		
Headaches, seizures, numbness, neuropathy?		
Arthritis, joint problems, joint replacement?		
Depression, bi-polar, ADHD?		
Breathing, lung problems?		
Do you use oxygen?		
Immunosuppression, autoimmune disease?		
Rapid heartbeat with epinephrine?		
Defibrillator, pacemaker?		
Artificial heart valve?		
Artificial joints within past two years?		
Pregnancy or planning a pregnancy? (females)		
Blood thinners, problems with bleeding?		
Allergy to adhesive?		
Allergy to lidocaine?		
Allergy to topical antibiotic ointments?		
Premedication prior to procedures?		
Problems with healing, scarring or keloid?		

Other Symptoms: _____