Dallas Diagnostic Association – Plano
Dermatology Questionnaire

Date: _____ Name: _____

Date of Birth: _____ Occupation: _____ Daytime Phone #: _____

Did another physician refer you to our office? If so, the following information is necessary to allow us to communicate to your referring physician about your skin condition.

Referring Physician Name: _____ Phone #: _____

Referring Physician's Address: _____ City: _____ State: _____ Zip: _____

Your Past Medical History (check and describe)

Previous Skin Cancer:

- o Melanoma
- o Basal Cell
- o Squamous Cell
- o Other

Location: _____

Surgery Performed? _____

Other Cancers: _____

- o Asthma
- o Hepatitis
- o Seasonal Allergies
- o HIV/AIDS
- o Others (list): _____.

Your Past Surgical History:

Year Type of Surgery

_____

_____

_____

Your Family's Medical History Which Relatives?

- o Melanoma _____
- o Basal Cell Cancer _____
- o Squamous Cell Cancer _____
- o Seasonal Allergies _____
- o Asthma _____
- o Psoriasis _____
- o Eczema/Atopic _____
- o Others (list) _____

Your Social History (check and answer)

Do you smoke? Yes No

Do you drink alcohol? Yes No

If yes, how often? _____

Tanning bed exposure? Yes No

If yes, describe _____

Do you wear sunscreen? Yes No

Daily? Yes No

What SPF? 15 30 45 Other __

Medications: (Please list ALL medications you are currently taking including over the counter and herbal medications)
Note: If your primary care physician is part of DDA/Baylor, you do not need to complete this section.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Pharmacy Name (Please provide address & telephone)

_____

Allergies to medications? Yes No

If yes, please list _____

_____