

PATIENT QUESTIONNAIRE

Date: _____

Patient: _____

PLEASE LIST ANY ALLERGIES TO ANY MEDICATIONS:

ARE YOU TAKING ANY MEDICATIONS? Y/N

If yes, please list below:

PLEASE LIST YOUR MEDICAL PROBLEMS (OTHER THAN SKIN PROBLEMS):

HAVE YOU HAD A MELANOMA? Y/N

If yes:

WHEN: _____ **WHERE:** _____

HAVE YOU HAD BASAL CELL CARCINOMA? Y/N

If yes:

WHEN: _____ **WHERE:** _____

HAVE YOU HAD SQUAMOUS CELL CARCINOMA? Y/N

If yes:

WHEN: _____ **WHERE:** _____

IS THERE A FAMILY HISTORY OF?

MELANOMA Y/N

BASAL CELL CARCINOMA Y/N

SQUAMOUS CELL CARCINOMA Y/N