

**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**