Dr. Stephen 0. Kovacs, PC. The Dermatology and Skin Surgery Centers
77 Warren Street, Suite 353 - Brighton, MA 02135 - Telephone 617-787-0400 - FAX 617-500-0976
61 Lincoln Street, Suite 307 - Framingham, MA 01702 - Telephone 508-820-0700 - FAX 508-809-3804

HEALTH HISTORY QUESTIONNAIRE

DATE _____/_____/_____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:	☐ M ☐ F	DOB____/____/____
Height:	**Weight:**	**Referring Physician:**

PRESENT DERMATOLOGY HEALTH CONCERN(S)

Please describe your current dermatology/skin problem(s) and why you are seeking consultation.

ILLNESSES (Please check all that apply)

Have you ever been diagnosed with any of the following illnesses or medical problems? If yes, please include approximate date or year.

☐ High Blood Pressure	❒Yes ❒ No	Year:	☐ Multiple Sclerosis	❒Yes ❒ No	Year:
☐ Coronary Artery Disease	❒Yes ❒ No	Year:	☐ Parkinson's Disease	❒Yes ❒ No	Year:
☐ Heart Attack	❒Yes ❒ No	Year:	☐ Alzheimer's Disease	❒Yes ❒ No	Year:
☐ Angina	❒Yes ❒ No	Year:	☐ Thyroid Disease	❒Yes ❒ No	Year:
☐ Heart Failure	❒Yes ❒ No	Year:	☐ Diabetes	❒Yes ❒ No	Year:
☐ Mitral Valve Prolapse	❒Yes ❒ No	Year:	☐ HIV/AIDS	❒Yes ❒ No	Year:
☐ Cerebrovascular Accident (Stroke)	❒Yes ❒ No	Year:	☐ Transient Ischemic Attack	❒Yes ❒ No	Year:
☐ Pacemaker/Defibrillator	❒Yes ❒ No	Year:	☐ Deep Venous Thrombosis	❒Yes ❒ No	Year:
☐ Artificial Heart Valve	❒Yes ❒ No	Year:	☐ Genital Herpes	❒Yes ❒ No	Year:
☐ CHF	❒Yes ❒ No	Year:	☐ Hepatitis	❒Yes ❒ No	Year:
☐ Cardiac Arrhythmia	❒Yes ❒ No	Year:	☐ Liver Disease	❒Yes ❒ No	Year:
☐ Heart Murmur	❒Yes ❒ No	Year:	☐ Seizures	❒Yes ❒ No	Year:
☐ Artificial Joint	❒Yes ❒ No	Year:	☐ Hodgkin's Disease	❒Yes ❒ No	Year:
☐ Genital Condyloma	❒Yes ❒ No	Year:	☐ Lupus	❒Yes ❒ No	Year:
☐ Padget's Disease	❒Yes ❒ No	Year:	☐ Rheumatologic Disease	❒Yes ❒ No	Year:
☐ Anemia	❒Yes ❒ No	Year:	☐ Malignant Lymphoma	❒Yes ❒ No	Year:
☐ Leukemia	❒Yes ❒ No	Year:	☐ Blood Transfusion	❒Yes ❒ No	Year:
☐ Cervical/Ovarian Cancer	❒Yes ❒ No	Year:	☐ Serious Infection/Sepsis	❒Yes ❒ No	Year:
☐ Colon Cancer	❒Yes ❒ No	Year:	☐ Melanoma	❒Yes ❒ No	Year:
☐ Breast Cancer	❒Yes ❒ No	Year:	☐ Basal Cell Carcinoma	❒Yes ❒ No	Year:
☐ Bladder/Kidney Cancer	❒Yes ❒ No	Year:	☐ Squamous Cell Carcinoma	❒Yes ❒ No	Year:
☐ Prostate Cancer	❒Yes ❒ No	Year:	☐ Unusual Moles	❒Yes ❒ No	Year:
☐ Testis/Penile Cancer	❒Yes ❒ No	Year:	☐ Blistering Sunburn	❒Yes ❒ No	Year:
☐ Lung Cancer	❒Yes ❒ No	Year:	☐ Psoriasis	❒Yes ❒ No	Year:
☐ Asthma/Bronchitis	❒Yes ❒ No	Year:	☐ Eczema	❒Yes ❒ No	Year:
☐ Emphysema	❒Yes ❒ No	Year:	☐ Excessive Scarring	❒Yes ❒ No	Year:
☐ Shortness of Breath	❒Yes ❒ No	Year:	☐ Keloids	❒Yes ❒ No	Year:
☐ COPD	❒Yes ❒ No	Year:	☐ Severe Acne	❒Yes ❒ No	Year:

OPERATIONS

Please list all surgeries including approximate date or year.

Surgery	Diagnosis	Date/Year

MEDICATIONS

Please list your prescribed drugs and over-the-counter drugs, such as vitamins and nutritional supplements including approximate start date.

Name of Drug	Strength	Frequency Taken	Start Date/Year

ALLERGIES

Please list all drug allergies including type of reaction.

Name of Drug	Reaction

FAMILY HEALTH HISTORY

☐ **No History of Familial Disease**

Relative (i.e. Father, Mother, Sister, Brother, etc.)	Illness (i.e.Skin Cancer, etc.)

Advance Directive	☐ **None**	☐ **Living Will**	☐ **Surrogate**
Alcohol Use	☐ **None**	**Drinks:** ☐ **Occasionally** ☐ **Weekly** ☐ **Daily**	
Tobacco Use	☐ **None**	☐ **Packs per Day:** **Duration/years:** **Date Discontinued:**	

CERTIFICATION

The above information is true to the best of my knowledge.

Patient/Legal Guardian/Authorized Person (Signature)	Relationship If Other Than Patient
X	

MD Signature_____ **Date Reviewed:**_____