LAURA WAGNER, INC. **Health Questionnaire** **Date:** _____

PATIENT NAME: _____ **DOB:** _____

REASON FOR TODAY'S VISIT: _____

PATIENT PERSONAL HISTORY OF SKIN CANCER: (check all that apply… or check NONE)

☐ NONE ☐ Skin Cancer… type unknown ☐ I don't know

☐ Melanoma ☐ Squamous Cell Carcinoma ☐ Basal Cell Carcinoma ☐ Actinic Keratosis (pre-cancers)

Who did your skin cancer surgery or treatment?

MEDICATIONS: **Do you currently take any prescription medications?** ☐ Yes ☐ No

☐ I have listed my medications here: ☐ I have provided a separate list of my medications and drug allergies.

_____

_____

DRUG ALLERGIES: **Do you have any DRUG ALLERGIES?** ☐ Yes ☐ No *List prescription names & reaction to the drug.*

_____

_____

OTHER ALLERGIES: ☐ Latex ☐ Tape ☐ Band-aids ☐ List Other:

ALL PATIENTS - SURGICAL HISTORY ☐ Skin Cancer Surgery ☐ Other Surgery:

FEMALES – CHECK ANY OF THESE SURGERIES YOU HAVE HAD: ☐ Hysterectomy ☐ Tubal Ligation ☐ Sterilization

FAMILY HISTORY OF SKIN CANCER: check & circle all that apply.

☐ No Known Family History

☐ Melanoma ..... ***RELATIONSHIP TO YOU:*** MOTHER * FATHER * SIBLING * CHILD

☐ Squamous Cell Carcinoma ..... ***RELATIONSHIP TO YOU:*** MOTHER * FATHER * SIBLING * CHILD

☐ Basal Cell Carcinoma ..... ***RELATIONSHIP TO YOU:*** MOTHER * FATHER * SIBLING * CHILD

☐ Skin Cancer… type is unknown ..... ***RELATIONSHIP TO YOU:*** MOTHER * FATHER * SIBLING * CHILD

TRUE WEIGHT: _____ required for certain medications

SMOKING STATUS: ☐ Never Smoker ☐ Former Smoker-quit date _____ ☐ Current Smoke- how much daily? _____

FEMALES ONLY – CHECK ONE: ☐ Pregnant ☐ Nursing ☐ Trying to conceive ☐ None of these

HAVE YOU HAD THE FLU SHOT THIS SEASON? *Flu season is between October& March.*

☐ **YES**/approximate date: _____ ☐ **NO** (circle reason): not yet * declined * allergy to vaccine * other: _____

HAVE YOU EVER HAD THE PNEUMONIA SHOT? *Answer this question regardless of the date.*

☐ **YES**/approximate date: _____ ☐ **NO** (circle reason): not yet * declined * allergy to vaccine * other: _____

PATIENT MEDICAL HISTORY: Have you been diagnosed or treated for any of the following? ☐ **YES** ☐ **NONE**

Check all that apply.

☐ AIDS/HIV	☐ DIABETES	☐ HYPERTENSION	☐ STROKE
☐ ARTHRITIS	☐ EMPHYSEMA	☐ KIDNEY DISEASE	☐ THYROID PROBLEMS
☐ ARTIFICIAL HEART VALVE	☐ G.E.R.D.	☐ LIVER DISEASE	☐ TUBERCULOSIS
☐ ARTIFICIAL JOINT	☐ GLAUCOMA	☐ MIGRAINES	
☐ ASTHMA	☐ HEART DISEASE	☐ ORGAN TRANSPLANT	
☐ BLOOD THINNERS	☐ HEPATITIS: A * B * C	☐ OTHER CONDITION: please list:_____	
☐ CHEMOTHERAPY	☐ HERPES SIMPLEX VIRUS	☐ RADIATION THERAPY	
☐ COLITIS	☐ HIGH CHOLESTEROL	☐ SEIZURES	

☐ CANCER other than skin-Please note the **Type** of cancer:

CHECK ALL THAT APPLY TO YOU → ☐ **I HAVE A DEFIBRILLATOR** ☐ **I HAVE A PACEMAKER** ☐ **NONE**

ADVANCE DIRECTIVE – Complete this section if you are 65 years or older.

☐ **Have you received Hospice care this year?** ☐ Yes ☐ No

Do you have an Advanced Care Plan or Surrogate Decision Maker? Check one box below.

☐ Yes -What is their Name and Phone? (optional) _____

☐ No. I do not wish or I am not able to name a surrogate decision maker or provide an advance care plan.

PRIMARY CARE DOCTOR: Name: _____ Phone: _____

PHARMACY: Name: _____ Ph: _____ Street/Zip _____