

220 Southbrooke Drive
Waterloo, Iowa 50702

Dermatology Associates
Martin Sands, M.D. / Bryan Sands, D.O.

319-236-3444
FAX: 319-236-0257

Medical History Questionnaire

This information is for your Practitioner. Please print legibly.

DATE: _____

NAME: _____ BIRTHDATE: _____ MARITAL STATUS: S M D W

FAMILY PHYSICIAN: _____ REFERRED BY: _____

CURRENT MEDICATIONS:

- | | | |
|----------|-----------|-----------|
| 1. _____ | 6. _____ | 11. _____ |
| 2. _____ | 7. _____ | 12. _____ |
| 3. _____ | 8. _____ | 13. _____ |
| 4. _____ | 9. _____ | 14. _____ |
| 5. _____ | 10. _____ | 15. _____ |

MEDICATION ALLERGIES:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

FOOD OR OTHER ALLERGIES:

SKIN HISTORY:

Have you ever had skin cancer? ____ No ____ Yes : If yes, please list dates and location: _____

Has anyone in your family had skin cancer or melanoma? ____ No ____ Yes : If yes, list relationship and type: _____

PAST MEDICAL HISTORY:

- | | |
|--|--------------------------------------|
| ____ High Blood Pressure | How long? ____ years |
| ____ Diabetes | How long? ____ years |
| ____ High Cholesterol | How long? ____ years |
| ____ Stroke | Cause and When? _____ |
| ____ Seizure | What type, when and how often? _____ |
| ____ Headaches | What type and how often? _____ |
| ____ Cancer | What type and when? _____ |
| ____ Thyroid problems | What type and when? _____ |
| ____ Operations | What type and when? _____ |
| ____ Other significant health history : Please explain | _____ |

No Past Medical History

Any illness or operations in the last 6 months? _____

FAMILY HISTORY: (please provide relationship, age and any other significant illness or hereditary factors of grandparents, parents, brothers, sisters or children): _____

Do you smoke? ____ No ____ Yes - If yes, how many pack(s)/day, for how long? _____

Did you smoke? ____ No ____ Yes - If yes, how long & when did you quit? _____

Do you drink? ____ No ____ Yes - If yes, how much of what/day or week? _____

Have you or do you use recreational drugs? ____ No ____ Yes - If yes, what and how often? _____

FEMALES: Are you pregnant? ____ YES ____ NO-----**Due Date:** _____

Are you planning to become pregnant? ____ YES ____ NO---Are you currently nursing? ____ YES ____ NO

REVIEWED BY (date and initials) _____
