The Skin Institute
Rapid City Medical Center, LLP
2820 Mt. Rushmore Rd.
Rapid City, SD 57701
605-342-3280
rcskininstitute.com

PATIENT QUESTIONNAIRE

Patient Name: _____ **Today's Date:** _____

Family Dr. _____ Referring Dr. _____

What is the nature of your skin problem? _____

_____

Location _____ Duration _____ Onset _____

Has it been ☐ Itching ☐ Bleeding ☐ Non-Healing ☐ Changing size or color

Do you wear sunscreen? _____ Are you interested in cosmetic services? _____

Have you used/or using a tanning bed? _____

If you have ever had the problem listed, mark the yes column. If yes, give a short description of when the problem happened and how long it has been going on. Should you need more space to write use Page 4.

Are you currently having any of the following?

General

Yes ☐ No ☐ fever _____
Yes ☐ No ☐ night sweats _____
Yes ☐ No ☐ loss of appetite _____
Yes ☐ No ☐ weight loss or gain _____
Yes ☐ No ☐ bleeding _____
Yes ☐ No ☐ diabetes (sugar in blood) _____
Yes ☐ No ☐ thyroid problems _____
Yes ☐ No ☐ cancer _____
Yes ☐ No ☐ fatigue _____
Yes ☐ No ☐ depression or anxiety _____
Yes ☐ No ☐ sleep disturbance _____
Yes ☐ No ☐ history of infectious disease _____

Skin

Yes ☐ No ☐ dry skin _____
Yes ☐ No ☐ itching skin _____
Yes ☐ No ☐ rashes _____
Yes ☐ No ☐ bruising _____
Yes ☐ No ☐ lesions (sores) _____
Yes ☐ No ☐ hair loss _____
Yes ☐ No ☐ skin cancer _____

HEENT

Yes ☐ No ☐ visual changes or double vision _____
Yes ☐ No ☐ ear pain or discharge _____
Yes ☐ No ☐ nosebleeds _____
Yes ☐ No ☐ mouth sores _____

Chest, Heart, and Lungs

Yes ☐ No ☐ nipple discharge/rash _____
Yes ☐ No ☐ swelling of your feet _____
Yes ☐ No ☐ lung disease _____
Yes ☐ No ☐ heart disease _____
Yes ☐ No ☐ blood clots in lungs _____

Gastrointestinal

Yes ☐ No ☐ vomiting _____
Yes ☐ No ☐ abdominal pain _____
Yes ☐ No ☐ diarrhea _____
Yes ☐ No ☐ constipation _____
Yes ☐ No ☐ hepatitis _____

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Genitourinary

Yes ☐ No ☐ problems with kidneys _____

Yes ☐ No ☐ sexually transmitted diseases _____

Yes ☐ No ☐ discharge from genitals/rash _____

For Women Only

Yes ☐ No ☐ abnormal menstrual periods _____

Yes ☐ No ☐ menopause _____

Yes ☐ No ☐ contraception _____

Yes ☐ No ☐ are you pregnant or planning pregnancy _____

Musculoskeletal

Yes ☐ No ☐ joint pain or swelling _____

Yes ☐ No ☐ bone pain _____

Yes ☐ No ☐ gout _____

Yes ☐ No ☐ have you ever been diagnosed with lupus or rheumatoid arthritis _____

Yes ☐ No ☐ joint replacement _____

Neurologic

Yes ☐ No ☐ seizures _____

Yes ☐ No ☐ loss of consciousness or fainting _____

Yes ☐ No ☐ stroke _____

KNOWN ALLERGIES

Medications: _____

Foods: _____

PRESCRIPTION MEDICATIONS

(attach sheet if additional medications)

Do you take any other non-prescription drugs?

(such as laxatives, aspirin, herbal medications, street drugs)

List travel outside the US during the last 5 years

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HOSPITALIZATIONS / SURGERIES

Year	Illness / Surgery

☐ **Do you need antibiotics prior to surgery?**

SURGERY HISTORY:

Bleeding problems: Yes / No If yes, explain: _____
Blood thinner medications: Yes / No If yes, INR in the last 14 days? _____
Joint replacement/prosthesis: Yes / No If yes, explain: _____
Heart valve replacement: Yes / No If yes, explain: _____
Defibrillator/Pacemaker: Yes / No If yes, explain: _____
Medications/Anesthesia allergies: Yes / No If yes, explain: _____
Suture allergies: Yes / No If yes, explain: _____

FAMILY HISTORY—Check mark the box if your relative had a disorder listed.

Dysplastic nevi/abnormal moles:	grandparents ☐	father ☐	mother ☐	brother/sister ☐	children ☐
Autoimmune disease:	grandparents ☐	father ☐	mother ☐	brother/sister ☐	children ☐
Eczema:	grandparents ☐	father ☐	mother ☐	brother/sister ☐	children ☐
Psoriasis:	grandparents ☐	father ☐	mother ☐	brother/sister ☐	children ☐
Skin cancer:	grandparents ☐	father ☐	mother ☐	brother/sister ☐	children ☐
Melanoma:	grandparents ☐	father ☐	mother ☐	brother/sister ☐	children ☐
Inherited skin disorders:	grandparents ☐	father ☐	mother ☐	brother/sister ☐	children ☐

List other family diseases: _____

_____

Are your parents alive? Yes ☐ No ☐ If no, age at the time of their death? Mother: _____ Father: _____
What did they die of? Mother: _____ Father: _____

SOCIAL HISTORY

Location born: _____
Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Children: Yes ☐ No ☐ If yes, how many: _____
Do you use tobacco? Yes ☐ No ☐
Do you drink alcohol Yes ☐ No ☐

List your present occupation: _____
If retired or unemployed, list previous type of work: _____

Date: _____ **Patient Signature:** _____

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