Isabella Gyening, MD
1920 Country Place Parkway Suite 310
Pearland, Texas 77584

Medical History Questionaire

Patient Name: ______________________________ **Date of Birth**:______________

Medications you are currently taking: ______________________________________
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Allergies: ____

What is the primary reason for your visit today?

____

Have you or do you currently have: (check all that apply):

☐ Skin Cancer Type_______________ Location____________	☐ History of Cancer Type____________	☐ Hepatitis Type__________
☐ Lung Problems	☐ Asthma	☐ History of cold sores
☐ Blood Disorder	☐ Anemia	☐ Gluacoma
☐ Heart Valve Replacement	☐ History of Keloids	☐ Kidney disease
☐ Neurological disorder	☐ Low blood sugar	☐ Thyroid Disease
☐ High Blood Pressure	☐ Diabetes	☐ Joint Disease
☐ Immune System Disorder	☐ History of Stroke	☐ Sinus Problems
☐ Arthritis	☐ Pacemaker	☐ Seasonal Allergies
☐ History of Accutane use	☐ Ulcers/GI Disease	☐ Other:_______________

Have you had any surgical procedures in the past five years? ☐ **Yes** ☐ **No**
If yes, please describe: ____

Is there any family history of:			**(If yes, please describe family relation)**
☐ Yes	☐ No	Basal Cell Carcinoma	______________________
☐ Yes	☐ No	Squamous Cell Carcinoma	______________________
☐ Yes	☐ No	Melanoma	______________________
☐ Yes	☐ No	Vitiligo	______________________
☐ Yes	☐ No	Psoriasis	______________________
☐ Yes	☐ No	Other Skin Disease	______________________

Female Patients: (please check)

☐ Contemplating pregnancy ☐ Breastfeeding
☐ Pregnant ☐ Irregular Menses

All Patients:

Do you smoke tobacco? If so, how often: _______________________________________

Do you drink alcoholic beverages? If so, how often: _______________________________

Do you have a history of blistering sunburns or excessive sun exposure? _________________

Do you have a history of tanning bed use? When and how often? _____________________

Is there any other condition concerning your health that the doctor should be aware of? If so, please describe:

____

How did you hear about us? ____

If personally referred, whom may we thank for the referral? __________________________

Patient Signature: ______________________________ **Date**: ____________________