Medical History Questionnaire

Skin Growth / Rash / Acne

Chief Complaint: ________________________________________________________________

History of the Present Illness:
What is the location of the acne, growth or rash? _______________________________________

How you noticed it? ____________________________________________ How long? ___________

Extended (4 of 6) Acne
Any history of prior treatment? ___________ Any Response to this treatment? ___________

Current Medication? ____________________________________________________________

Menstrual Irregularities or taking of any hormones (Birth control pill)? ______________

Are you Pregnant? _______ Do you plan to become pregnant soon? ______________

Work or home exposure to chemical (pesticides, insecticides)? __________________________

Any prior episodes of this problem? _______________________________________________

Extended (4 of 6) Rash
Any history of prior treatment? ___________ Any response to this treatment? ___________

Current medication? ____________________________________________________________

What aggravates this condition? ___________________________________________________

Any prior episodes of this problem? _____ Any exposure to any known topical irritants? _____

Extended Growth
Does the growth burn/ itch/ sting or bleed? _____ Is the growth enlarging or changing? ______

Any history of prior treatments? ______________ Any history of tans/ burns/ injury? ______

Review of Systems:
Problem Acne or Rash
Any history of prior skin problems? _____ Any known allergies of skin sensitivities? ______

Any other problems of the skin, eyes, mouth, genitalia, hair or nails? ___________________

Any other relevant problems (endocrine or hormonal)? ________________________________
Problem Growth
Any history of prior pre-malignant lesions? ___Any history of prior malignant lesions? _______

Any history of prior skin surgery? _______________________________________________________

Are there any other skin areas with significant sun damage? ______________________________

Are there other skin, eye, mouth, genital, hair or nail problems? __________________________

Past Medical, Family and Social History:

Have you had any past history of any other skin diseases? ________________________________

Is there any history of skin disease in your family? _______________________________________

Are there similar problems among co-workers in your occupation? _________________________

Any exposure to cancer causing agents in prior occupations? ______________________________

This record reviewed by: ______________________________________________________________

                                               Michael C. Margulies, M.D.