

The LONDON CLINIC of DERMATOLOGY
CONFIDENTIAL MEDICAL QUESTIONNAIRE

Name: _____ DOB: ____/____/____

Occupation: _____ Reason for Visit: _____

Medical History: Please tick any boxes that apply if you **now or have ever** suffered from the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart disease/attack/pacemaker | <input type="checkbox"/> Aids risk/HIV | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Eczema/Dermatitis/Psoriasis | <input type="checkbox"/> Cancer – specify _____ | <input type="checkbox"/> Lichen Planus |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Headache/migraine | <input type="checkbox"/> Hepatitis A, B or C |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Herpes/Cold sores | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Lung or Breathing Disorders | <input type="checkbox"/> Lupus/LE | <input type="checkbox"/> Keloid Scar/Poor wound healing |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Neurological/Epilepsy | <input type="checkbox"/> Anaemia |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Heart valve trouble |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Gut & Bowel Disease | <input type="checkbox"/> Blistering Sunburn before age 12 |
| <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Varicose Veins/spider veins | <input type="checkbox"/> Blistering Sunburn |

Please list any **operations or hospitalisations** you have **ever** had: _____

Is there **anything else** not listed, that you currently have or have ever had treatment from a doctor for?
Please specify: _____

Are you **allergic or hypersensitive** to anything? I.e. Drug, food, local anaesthetic, dust, pollen, chemical:
please specify: _____

Please list any **medications** you currently take including **prescribed, over the counter, herbal or Chinese remedies** (include dose and frequency): _____

Please only tick boxes that apply:

- Do you ingest, inhale or inject any illicit/recreational substances? Please list: _____
- Are you pregnant? Or think you may be pregnant? Do you need antibiotics before dental work?
- Do you take blood thinners i.e. Aspirin or warfarin Do you take 'the pill' or injection? which _____
- Have you ever taken Roaccutane? If yes, when? _____

Family History: Are any of the following illness/conditions in your immediate family; parents, siblings, children?

- | | | | |
|------------------------------------|---|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Anaemia | <input type="checkbox"/> Acne | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Vitiligo | <input type="checkbox"/> Keloid Scars |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Skin cancer: type? _____ | | |

Life Style:

Smoking Yes No Cigarettes/week _____

Alcohol Yes No Units/week _____

Tea/coffee Yes No Cups/day _____

Sun tanning frequency? (sun beds or bathing) _____

Sun block factor and type used _____

Have you ever had **Laser treatment, implants or cosmetic procedures**? I.e. Tissue, collagen, gels, silicon, Botox, facial: _____

It is essential that you complete this form accurately. Failure to do so may result in incorrect treatment and compromise your safety, for which the London Clinic of Dermatology will not be responsible.

Signature: _____ Date: _____