Edward Ruiz, M.D., P.C.

Dermatology Medical Questionnaire

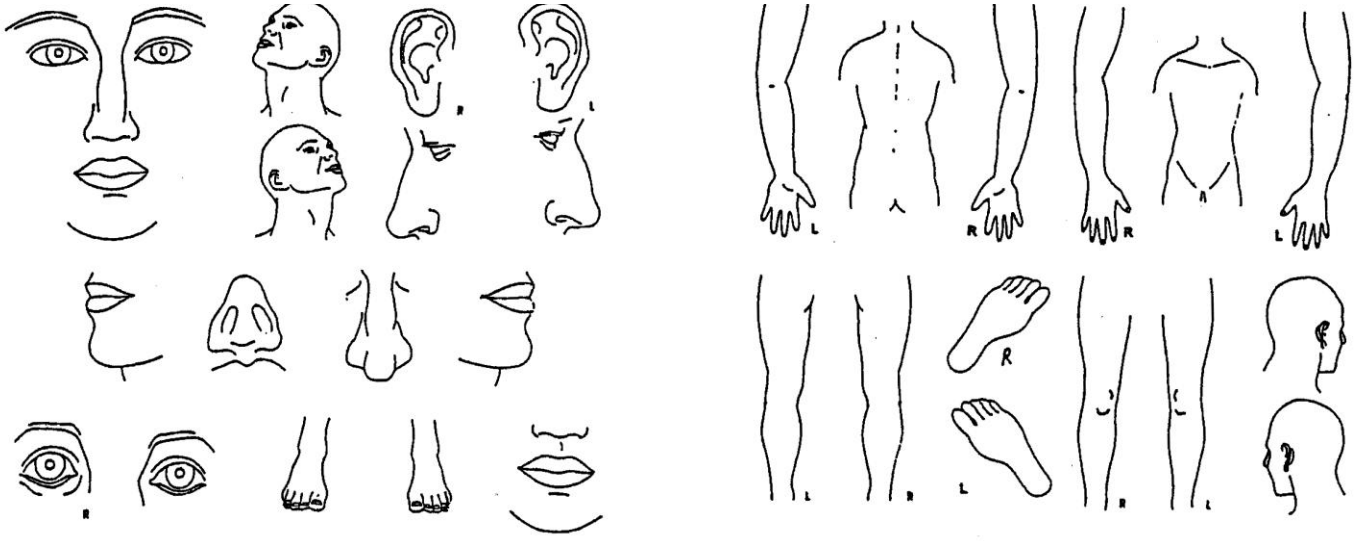
Name: _____Date of Birth:_____Age:_____
Last First MI

Telephone:Home (_____)_____Work (_____)_____Cell (_____)_____

PCP or Referring Physician_____Phone(____)_____
Name or Relative or Close Friend not living with you _____
Phone (_____)_____

Describe the *nature* and *duration* of your present problem(S): _____
_____
_____

If possible, show the location(s) of the problem(s):



Are you allergic to: adhesive tape or Band-Aids? _____Latex?_____Iodine?_____
List *Allergies to Medications* taken by mouth, injection or applied to the skin: _____
_____
_____

List *medications used daily* by mouth, injection or applied to the skin: _____
_____
_____
_____

List all *medications used in the last 4 weeks* by mouth, injection or applied to the skin: _____
_____
_____
_____

(Birth control pills, Antibiotics, Aspirin, Tylenol, Motrin/Advil, Aleve, Vitamins, Herbs, Laxatives, etc.)