



## QUESTIONNAIRE

To help give you the best possible care, please carefully complete all questions on this form.

### A. HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING:

- |  |     |    |
|--|-----|----|
| 1. Duodenal or peptic ulcer                | yes | no |
| 2. Other intestinal disease or colitis     | yes | no |
| 3. Liver disease or gall bladder disease   | yes | no |
| 4. Lung disease                            | yes | no |
| 5. Heart disease                           | yes | no |
| 6. High blood pressure                     | yes | no |
| 7. Stroke                                  | yes | no |
| 8. Kidney disease                          | yes | no |
| 9. Urinary or bladder problem or infection | yes | no |
| 10. Venereal disease                       | yes | no |
| 11. Blood disorder or lymph gland disorder | yes | no |
| 12. Eye disease (glaucoma, cataract)       | yes | no |
| 13. Arthritis, joint problem, bone disease | yes | no |
| 14. Thrombophlebitis                       | yes | no |
| 15. Cancer                                 | yes | no |
| 16. Neurological disorder                  | yes | no |
| 17. Frequent infections                    | yes | no |
| 18. Emotional or psychiatric problem       | yes | no |

### B. HAVE YOU OR ANY MEMBERS OF YOUR FAMILY (Specify Who) HAD:

- |                                    |     |    |
|------------------------------------|-----|----|
| 1. Asthma                          | yes | no |
| 2. Hay fever                       | yes | no |
| 3. Eczema                          | yes | no |
| 4. Hives                           | yes | no |
| 5. Diabetes                        | yes | no |
| 6. Psoriasis                       | yes | no |
| 7. Skin cancer                     | yes | no |
| 8. Glaucoma                        | yes | no |
| 9. Other skin conditions (specify) | yes | no |

### C. HAVE YOU EVER HAD?

Difficulty with the healing of wounds

- |                                 |     |    |
|---------------------------------|-----|----|
| 2. Overgrown scars or keloids   | yes | no |
| 3. Allergy to local anesthetics | yes | no |

**D. HAVE YOU PREVIOUSLY HAD A SKIN PROBLEM OR BEEN UNDER THE CARE OF A DERMATOLOGIST? IF YES, DESCRIBE:**

\_\_\_\_\_

**E. HAVE YOU EVER HAD RADIATION?** yes    no

**F. DO YOU TAKE ANY MEDICINES OR OVER-THE-COUNTER PREPARATIONS OR REMEDIES?** yes    no  
**PLEASE LIST** \_\_\_\_\_

**G. ARE YOU ALLERGIC TO ANY MEDICINES?** yes    no  
**IF YES, PLEASE LIST:** \_\_\_\_\_

**H. PRIOR HOSPITALIZATIONS AND SURGERY (Please give dates):**

\_\_\_\_\_  
\_\_\_\_\_

**I. FOR WOMEN ONLY**

- |  |     |    |
|--|-----|----|
| 1. Have you had vaginal yeast infections?  | yes | no |
| 2. Are you pregnant?                       | yes | no |
| 3. Are you currently planning a pregnancy? | yes | no |

**Please inform Dr. Green at any time if you do plan to or become pregnant during your treatment period.**

**At the time of your first visit to this office, it is necessary for your entire skin to be examined. This will enable Dr. Green to see not only the particular skin condition for which you are consulting us, but also other skin problems of which you may not be aware.**

**You will be provided with a proper gown for your examination.**

**If for any reason you do not wish to have such a general examination of your skin, please tell Dr. Green and she will make a note on your chart regarding your wishes.**

**DATE** \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_

**MICHELE S. GREEN, M.D.**  
**156 EAST 79TH STREET**  
**SUITE 1B**  
**NEW YORK, NEW YORK 10075**  
**PHONE (212) 535-3088**  
**FAX (212) 535-0279**

**DATE:** \_\_\_\_\_

**DEAR PATIENT IN ORDER TO HELP YOU KEEP YOUR MEDICAL HISTORY UP TO DATE PLEASE LIST ALL PHYSICIANS YOU WOULD LIKE US TO SEND YOUR PATHOLOGY AND LAB REPORTS TO:**

**To:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**To:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

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**Signature**

**Print**

**Michele S. Green, M.D.**  
**156 East 79<sup>th</sup> Street**  
**Suite 1B**  
**New York, NY 10075**

**ACKNOWLEDGEMENT OF  
RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**Patient Acknowledgement**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (“PHI”) about you. You have the right to review our Notice and ask questions about our privacy practices. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by calling (212) 535-3088. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you acknowledge that you have received our Notice of Privacy Practices.

\_\_\_\_\_  
**Name of Patient**

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**