PLASTIC SURGERY OF CENTRAL JERSEY **(609) 585-0044**

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name:		**Gender:** Male / Female	**DOB:**
Previous or referring doctor:			

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Check the boxes to the right to describe the symptoms below:	**YES**	**NO**
How long has the lesion/cyst been present ________________________ (duration)		
Has there been a recent change in size?		
Has there been a recent change in color?		
Has there been a recent change in shape?		
Is it irritated?		
Does it bleed?		
Is it painful or tender?		
Was **this** lesion biopsied by a Dermatologist or other physician?		
Did you have skin lesions removed in the past?		

Signature:____ **Date:**____________________