

# Medical History

Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Today's date: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

## DRUG ALLERGIES

Are you allergic to any medications?  No  Yes (Please indicate name of medications)

Circle any other **allergies**: local anesthetics including dental anesthesia (Novacaine) rubber/latex, tape/bandages topical antibiotics

MEDICATIONS you are currently taking (including over the counter, vitamins, herbs, and supplements):

## GENERAL MEDICAL HISTORY

Do you have a past or present history of any of the following?

	NO	YES		NO	YES
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blister/Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease (Emphysema/COPD)	<input type="checkbox"/>	<input type="checkbox"/>	Cancer-Type: _____	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat/Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Bruise or bleed easily	<input type="checkbox"/>	<input type="checkbox"/>

Other diseases/ conditions/ recent surgeries \_\_\_\_\_

## SKIN HISTORY

When you are exposed to sun do you:  Tan only  Tan and burn  Burn How many times? \_\_\_\_\_

Have you ever had skin cancer?  NO  YES Basal Cell, Squamous Cell or Melanoma \_\_\_\_\_

Has anyone in your family had skin cancer  NO  YES If yes, who & type? \_\_\_\_\_

Do you have any difficulty in wound healing or form unsightly or unusual scars?  NO  YES

## SOCIAL HISTORY

Do you drink alcohol? \_\_\_\_\_ drinks/day Do you smoke? \_\_\_\_\_ packs/day

Have you used IV drugs? \_\_\_\_\_

Occupation: \_\_\_\_\_

IS IT OK TO LEAVE VOICEMAIL FOR LAB RESULTS?  NO  YES

PREFERRED MESSAGE PHONE # \_\_\_\_\_

Would you like more information on the cosmetic procedures we offer?

Yes ( ) No ( )

( ) Fotofacial RF (skin rejuvenation) ( ) Fillers ( ) Microdermabrasion  
( ) Laser Hair Removal ( ) Botox ( ) Sclerotherapy  
( ) Chemical peels

\_\_\_\_\_  
Signed By Patient or Guardian Date

\_\_\_\_\_  
Signed by Physician Date