Medical History

Name: _____ **Date of Birth:** _____

MEDICAL/SURGICAL HISTORY:

Do you have now or have you ever had:

	(**please circle**)	
High blood pressure	Yes	No
Diabetes/High blood sugar	Yes	No
Asthma	Yes	No
Tuberculosis	Yes	No
Thyroid problems	Yes	No
Hayfever/Seasonal allergies	Yes	No
Seizures	Yes	No
Stroke or Mini-Stroke	Yes	No
Heart attack/Angina	Yes	No
Pacemaker	Yes	No
Heart murmur/Palpitations	Yes	No
Kidney/bladder problems	Yes	No
Prostate problems	Yes	No
HIV/AIDS	Yes	No
Glaucoma	Yes	No
Hepatitis B or C/Liver Disease	Yes	No
Recurrent yeast infections	Yes	No
Bowel disease/Colitis/Crohn's	Yes	No
Frequent/Severe headaches	Yes	No
Cancer other than skin	Yes	No
Radiation	Yes	No
Artificial joint heart valve	Yes	No
Past surgery	Yes	No

Other

If YES to any above, please explain:

_____

_____

_____

CURRENT HEALTH:

Do you smoke?	Yes	No
How much?_____		
Do you drink alcohol?	Yes	No
How much?_____		
Do you use drugs?	Yes	No
How much?_____		

MEDICATIONS:

List all medications you are taking, including any over-the-counter herbals or vitamins:

_____

_____

_____

_____

_____

DERMATOLOGIC HISTORY:

Do you have now or have you ever had:

	(**please circle**)	
Keloids/Abnormal scarring	Yes	No
Poor wound healing	Yes	No
Skin pigmentation problems	Yes	No
Reaction to local anesthetic	Yes	No
Cold sores/Herpes infections	Yes	No
Eczema	Yes	No
Psoriasis	Yes	No
Abnormal ("Dysplastic") moles	Yes	No
Precancerous spots	Yes	No
Skin Cancer - Melanoma	Yes	No
Skin Cancer -Basal Cell	Yes	No
Skin Cancer -Squamous Cell	Yes	No
Abnormal cold sensitivity	Yes	No
Abnormal sun sensitivity	Yes	No
Cosmetic surgery	Yes	No

If YES, to any above, please explain:

_____

_____

ALLERGIES:

Are you sensitive/allergic to any medications?
(Oral medications, topical creams/ointments, etc.)
Please list:

_____

_____

_____

FAMILY HISTORY:

Do you have a family history of:

Allergies/Asthma		Yes	No
Skin Cancer:	Basal/Squamous	Yes	No
	Melanoma	Yes	No
Abnormal ("Dysplastic") moles		Yes	No
Other skin disorder		Yes	No

FEMALES:

Excess facial/body hair	Yes	No
Regular menstrual periods	Yes	No
Are you pregnant or nursing?	Yes	No

Names/ages of your children:

_____

_____

_____

This office sends out newsletters and occasional promotions and announcements regarding new services or special offers. Please sign and date below to indicate if you would like to be included in these mailings.

_____ Yes or No (please circle one)