



# Medical History

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

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

## **DRUG ALLERGIES**

Are you allergic to any medications?  No  Yes Please list: \_\_\_\_\_

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

## **PRESCRIPTION MEDICATIONS** you are currently taking

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

## **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 Blisters/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 for \_\_\_\_\_ yrs

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

IS IT OK TO LEAVE VOICE MAIL FOR LAB RESULTS?  NO  YES PREFERRED MESSAGE PHONE # \_\_\_\_\_

Would you like more information on the cosmetic procedures we offer? Yes( ) No( )

- ( ) Fillers      ( ) Microdermabrasion      ( ) Intense Pulse Light Skin Rejuvenation      ( ) Skin care products  
 ( ) Botox      ( ) Chemical peels      ( ) Hair removal

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

Signed By Physician \_\_\_\_\_ Date \_\_\_\_\_