Name:
Age: DOB:
DOS:
MRN: INS:
Doctor:

Medical History Form

☐ **Scan back of form**

Primary Doctor/Clinic: ________________ **Referred by your doctor? Yes / No**

Reason for today's visit: ________________

Do you have cosmetic concerns? Yes / No Circle: Botox, Voluma, Juvederm, Veins, Hair removal, Wrinkles, Brown spots

ALLERGIES: ________________

MEDICATIONS: ________________

Skin Conditions and Social History	**Yes**	**No**
Have you had skin cancer?	☐	☐
Melanoma?	☐	☐
Basal Cell Carcinoma?	☐	☐
Squamous Cell Carcinoma?	☐	☐
Have you had abnormal / dysplastic moles?	☐	☐
Have you had pre-cancerous Actinic Keratoses?	☐	☐
List any other skin conditions you have:	☐	☐
(Examples: Eczema, Psoriasis, Acne, Rosacea, Vitiligo) ________________		
Do you use sunscreen? SPF #__________	☐	☐
Have you used a tanning bed more than 25 times in your life? Total #_________	☐	☐
Have you had blistering sunburns?	☐	☐
Do you heal with thick (keloid) scars?	☐	☐
Do you bleed / bruise easily?	☐	☐
Are you sensitive to bandages or adhesive?	☐	☐
Do you need antibiotics for dental appointments?	☐	☐
Have you had staph infections / MRSA?	☐	☐
Do you smoke? # cigarettes/day_______	☐	☐
Do you drink alcohol? # drinks/day______	☐	☐
Have you worked outdoors?	☐	☐

List any foreign countries you have visited in the past six months: ________________

Occupation: ________________

Hobbies:

ROS: Circle any *Symptoms* you currently have:

General	weight loss	fatigue
Immune	fever night sweats	frequent infections
Eye	dryness blurry vision irritation	
Heart	chest pain ankle swelling palpitations	
Lungs	shortness of breath	cough
GI	nausea vomiting	diarrhea
Joint	stiffness pain	cramping
Neuro	numbness tingling headaches weakness	
Endocrine	heat/cold intolerance	excessive thirst
Psych	depression	anxiety
Heme	easy bleeding bruising swollen nodes	
Skin	itch burning redness discoloration scale	
Females	pregnant nursing irregular periods planning pregnancy IUD birth control pills	

Past Surgeries:	**Yes**	**No**
Pacemaker / Defibrillator	☐	☐
Joint replacement-Site:________________	☐	☐
Heart valve replacement	☐	☐
Organ transplant-Type:________________	☐	☐
Tubal ligation	☐	☐
List other surgeries ________________		

FAMILY Medical Problems:	**Yes**	**No**
Skin cancer	☐	☐
Melanoma?	☐	☐
Basal Cell Carcinoma?	☐	☐
Squamous Cell Carcinoma?	☐	☐
Abnormal moles	☐	☐
Eczema	☐	☐
Asthma	☐	☐
Seasonal Allergies	☐	☐
Psoriasis	☐	☐
Autoimmune diseases	☐	☐
(lupus, rheumatoid arthritis, MS, Crohn's, colitis, thyroid)		

PAST Medical History: Please circle

Cancer	breast prostate	colon _______
Immune	HIV immune deficiency	
Eye	glaucoma cataract	rosacea
Nose	seasonal allergies	chronic rhinitis
Heart	high blood pressure	heart attack
	high cholesterol	atrial fibrillation
	heart valve problems	clotting disorder
Lung	COPD asthma	tuberculosis
GI	acid reflux colitis	irritable bowel
	Hepatitis B or C	
Joint	arthritis joint replacement	
Brain	stroke seizures migraine headaches	
Endocrine	thyroid diabetes polycystic ovary	
Psych	depression anxiety attention deficit	
OTHER	________________	

Patient signature: ________________ Date: ________

Doctor signature:________________ Date:________

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