

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:** \_\_\_\_\_

<b>Skin Conditions and Social History</b>	<b>Yes</b>	<b>No</b>	<b>PAST Surgeries:</b>	<b>Yes</b>	<b>No</b>
Have you had skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker / Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma?	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement-Site: _____	<input type="checkbox"/>	<input type="checkbox"/>
Basal Cell Carcinoma?	<input type="checkbox"/>	<input type="checkbox"/>	Heart valve replacement	<input type="checkbox"/>	<input type="checkbox"/>
Squamous Cell Carcinoma?	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant-Type: _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had abnormal / dysplastic moles?	<input type="checkbox"/>	<input type="checkbox"/>	Tubal ligation	<input type="checkbox"/>	<input type="checkbox"/>
Have you had pre-cancerous Actinic Keratoses?	<input type="checkbox"/>	<input type="checkbox"/>	List other surgeries _____		
List any other skin conditions you have: (Examples: Eczema, Psoriasis, Acne, Rosacea, Vitiligo)	<input type="checkbox"/>	<input type="checkbox"/>			
_____			<b>PERSONAL Past Medical History: Please circle</b>		
Do you use sunscreen?   SPF # _____	<input type="checkbox"/>	<input type="checkbox"/>	<b>Cancer</b> breast   prostate   colon _____		
Have you used a tanning bed more than 25 times in your life?   Total # _____	<input type="checkbox"/>	<input type="checkbox"/>	<b>Immune</b> HIV   immune deficiency		
Have you had blistering sunburns?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Eye</b> glaucoma   cataract   rosacea		
Do you heal with thick (keloid) scars?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Nose</b> seasonal allergies   chronic rhinitis		
Do you bleed / bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Heart</b> high blood pressure   heart attack		
Are you sensitive to bandages or adhesive?	<input type="checkbox"/>	<input type="checkbox"/>	high cholesterol   atrial fibrillation		
Do you need antibiotics for dental appointments?	<input type="checkbox"/>	<input type="checkbox"/>	heart valve problems   clotting disorder		
Have you had staph infections / MRSA?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Lung</b> COPD   asthma   tuberculosis		
Do you smoke? # cigarettes/day _____	<input type="checkbox"/>	<input type="checkbox"/>	<b>GI</b> acid reflux   colitis   irritable bowel		
Do you drink alcohol? # drinks/day _____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C		
Have you worked outdoors?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Joint</b> arthritis   joint replacement		
List any foreign countries you have visited in the past six months: _____			<b>Brain</b> stroke   seizures   migraine   headaches		
Occupation: _____			<b>Endocrine</b> thyroid   diabetes   polycystic ovary		
Hobbies: _____			<b>Psych</b> depression   anxiety   attention deficit		
			<b>OTHER</b> _____		
<b>ROS: Circle any Symptoms you currently have:</b>			<b>FAMILY Medical Problems:</b>		
<b>General</b> weight loss   fatigue			Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>
<b>Immune</b> fever   night sweats   frequent infections			Melanoma?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Eye</b> dryness   blurry vision   irritation			Basal Cell Carcinoma?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Heart</b> chest pain   ankle swelling   palpitations			Squamous Cell Carcinoma?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Lungs</b> shortness of breath   cough			Abnormal moles	<input type="checkbox"/>	<input type="checkbox"/>
<b>GI</b> nausea   vomiting   diarrhea			Eczema	<input type="checkbox"/>	<input type="checkbox"/>
<b>Joint</b> stiffness   pain   cramping			Asthma	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neuro</b> numbness   tingling   headaches   weakness			Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>
<b>Endocrine</b> heat/cold intolerance   excessive thirst			Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
<b>Psych</b> depression   anxiety			Autoimmune diseases	<input type="checkbox"/>	<input type="checkbox"/>
<b>Heme</b> easy bleeding   bruising   swollen nodes			(lupus, rheumatoid arthritis, MS, Crohn's, colitis, thyroid)		
<b>Skin</b> itch   burning   redness   discoloration   scale			<b>Patient signature:</b> _____	Date: _____	
<b>Females</b> pregnant   nursing   irregular periods			<b>Doctor signature:</b> _____	Date: _____	
planning pregnancy   IUD   birth control pills					