Medical History

Patient:______________________________ Age:______________ Today's date: ______________

Reason for today's visit:____

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

____

____

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

GENERAL MEDICAL HISTORY

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

	NO	YES	If yes explain
Asthma			
Eczema			
Seasonal Allergies			
Lung Disease (Emphysema/COPD)			
High Blood Pressure			
High Cholesterol			
Heart Attack			
Irregular Heartbeat/Heart Murmur			
Pacemaker			
Artificial Joint			
Lupus			
Thyroid Disorder			

	NO	YES	If yes explain
Fever Blister/Cold Sores			
HIV			
Hepatitis			
Cancer-Type: ______________			
Diabetes			
Kidney Disease			
Gastrointestinal Disease			
Seizures			
Fainting			
Arthritis			
Bruise or bleed easily			

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 If yes, would you like information on how to quit smoking? ______________

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
Coolsculpting Botox Sclerotherapy
Chemical peels Microneedling

Yes, I wish to be added to your monthly email specials

____

E-mail Address

______________________ ______________
Signed By Patient or Guardian Date

______________________ ______________
Signed by Physician Date