DERMATOLOGY MEDICAL HISTORY

Patient Name:_____Date:_____

Reason for today's visit:_____

Are you allergic to any medications? ___Yes ___No

1._____ 2._____
3._____ 4._____

List all medications you are currently taking (including prescriptions, over the counter meds, vitamins, and herbals):

1._____ 2._____
3._____ 4._____

Do you have now, or have you ever had diseases or conditions of: (Please highlight Yes or No)

Lungs:

Bronchitis	__Yes	__No
Emphysema	__Yes	__No
Asthma	__Yes	__No
Chronic Cough	__Yes	__No
Morning Cough	__Yes	__No
Wheezing	__Yes	__No

Cardiovascular:

High Blood Pressure	__Yes	__No
Chest Pain	__Yes	__No
Heart Attack	__Yes	__No
Irregular Heartbeat	__Yes	__No
Phlebitis	__Yes	__No
Inflammation of veins	__Yes	__No
Blood Clots	__Yes	__No
Pacemaker	__Yes	__No
Fainting	__Yes	__No

Other Systemic:

Diabetes	__Yes	__No
Excessive thirst/hunger	__Yes	__No
Thyroid	__Yes	__No
Kidney	__Yes	__No
Bladder	__Yes	__No
Frequency/burning	__Yes	__No

Gastrointestinal:

Stomach absorptive disorder	__Yes	__No
Nausea, vomitting, diarrhea when taking antibiotics	__Yes	__No
Yeast infection when taking antibiotics	__Yes	__No
Arthritis/Joint Deformity	__Yes	__No
Arthralgia	__Yes	__No
Limited motion	__Yes	__No
Artificial joint	__Yes	__No
Convulsions, Seizures	__Yes	__No

Skin:

When you are exposed to the sun do you: __Tan only __Tan and burn __Burn only
Have you ever had skin cancer? __Yes __No
Has anyone in your immediate family had skin cancer? __Yes __No If yes, what type?_____
Do you have a history of any specific skin diseases? __Yes __No
If yes, please list:_____
Do you develop skin rashes in reaction to __Medications __Food __Environment?
List any other diseases or conditions:_____
List any surgical procedures you have had in the last 6 months:_____

Please answer the following questions:

Have you had or have you been exposed to HIV/AIDS __Yes __No
Do you bleed easily? __Yes __No
(Women) Are you pregnant? __Yes __No

__Please check here if you would like to learn more about our skin care products or if you would like a consultation with our esthetician. ___ Not Interested

Please indicate whether you are interested in learning more about the following: (Please Check)

__BOTOX__JUVEDERM__RESTYLANE__LASER HAIR REMOVAL__MICRODERMABRASION
__CHEMICAL PEELS__LASER FOR BROKEN VEINS__FRAXEL FOR ACNE SCARS __LASER FOR BROWN SPOTS__SCLEROTHERAPY__PRP HAIRLOSS__MICRONEEDLING __COOLSCULPTING__TRUSCULPT

All procedures are done in the office. If any of these are of interest to you, please let us know and we can discuss them with you as well as provide information.

Completed by: __Patient
__Medical Assistant

_____
Patient Signature Date