Patient Medical History

Patient Name:	____________________	Height:	_____
Weight:	_____	DOB:	_____

Past Medical History

Anxiety	□ Yes □ No	Pacemaker	□ Yes □ No
Asthma/Allergies	□ Yes □ No	Radiation Treatment	□ Yes □ No
Artificial Joints	□ Yes □ No	Epilepsy/Seizures	□ Yes □ No
Atrial Fibrillation	□ Yes □ No	Stent/Bypass	□ Yes □ No
Blood Thinners	□ Yes □ No	Stroke	□ Yes □ No
Depression	□ Yes □ No	Valve Replacement	□ Yes □ No
Diabetes	□ Yes □ No	Weight Gain or Loss	□ Yes □ No
GERD	□ Yes □ No	Pregnant or Planning Pregnancy	□ Yes □ No
Hearing Loss	□ Yes □ No	Are you breastfeeding?	□ Yes □ No
HEP/HIV	□ Yes □ No	Take antibiotics before procedures?	□ Yes □ No
Hypertension	□ Yes □ No	Yeast infections w/ antibiotics	□ Yes □ No
Keloids (Healing issues)	□ Yes □ No	Autoimmune disease history	□ Yes □ No
Other: __________________________			

Past Surgical History

Joint Replacement, knee	□ Yes □ No	Joint Replacement within last 2 years	□ Yes □ No
Joint Replacement, hip	□ Yes □ No	Skin Biopsy	□ Yes □ No
Basal Cell Cancer Surgery	□ Yes □ No	Squamous Cell Carcinoma Surgery	□ Yes □ No
Melanoma Surgery	□ Yes □ No	If Yes, level/stage: _____ Year: _____	
Other: __________________________		Metal implants?	□ Yes □ No

Skin Disease History

Acne	□ Yes □ No	Dry Skin/Eczema	□ Yes □ No
Psoriasis	□ Yes □ No	Blistering Sunburns	□ Yes □ No
Flaking or Itchy Scalp	□ Yes □ No	Poison Ivy	□ Yes □ No

Melanoma	□ Yes □ No	Squamous Cell Cancer	□ Yes □ No
Basal Cell Cancer	□ Yes □ No	Actinic Keratosis	□ Yes □ No
Precancerous Moles	□ Yes □ No	Other: ________________	

General Skin Questions

Do you wear sunscreen? □ Yes □ No (If yes, SPF: ________)

Would you consider your skin dry? □ Yes □ No

Does your skin bruise or break easily? □ Yes □ No

Have you had a recent full skin exam? □ Yes □ No

Is your facial skin always red or do you have broken blood vessels? □ Yes □ No

Do you want to learn about treatments to prevent skin cancers? □ Yes □ No

Family History of Skin Cancer:

Basal Cell Carcinoma	□ Yes	□ No
Squamous Cell Carcinoma	□ Yes	□ No
Malignant Melanoma	□ Yes	□ No

Allergies and Medications

Drug Allergies:

____

____

Current Medications (Prescription and OTC, including facial topicals):

_________________ Dose: _____ Frequency: ____

_________________ Dose: _____ Frequency: ____

_________________ Dose: _____ Frequency: ____

_________________ Dose: _____ Frequency: ____

Social History

Sexual Activity	Smoking Status	Alcohol Use (Male)	Alcohol Use (Female)

□ Not sexually active	□ Never Smoked	How many times in the past year have	How many times in the past year have
□ Sexually active	□ Quit: Former Smoker	you had more than 5 drinks in one day?	you had more than 4 drinks in one day?
		□ None □ Less than 2 times □ More than 2 times	□ None □ Less than 2 times □ More than 2 times

Cosmetic Dermatology

History of facial surgeries? □ Yes □ No (If yes, when: ___________)

Cosmetic injectables (Botox or fillers)? □ Yes □ No (Last injection: ___________)

History of Accutane use? □ Yes □ No (If yes, when: ___________)

Skin rejuvenation treatments? □ Yes □ No

History of Cold Sores? □ Yes □ No

Interested in anti-aging treatments or products? □ Yes □ No

Do your eyelids droop? □ Yes □ No

Interested in cosmetic treatments? □ Yes □ No

Other Health-Related Conditions Not Previously Identified:

____

Reason for Today's Visit (Chief Complaint):

____

Additional Information

Are you currently under another physician/technician for the care of your skin? □ Yes □ No

Pharmacy Information:

Name: _______________________ Phone Number: ________________________

Primary Care Physician:

Name: _______________________ Phone Number: ________________________

Parent/Guardian Information (if patient is a minor):

Name: ____________________________________ Phone Number(s):

____