Medical History Form

Name: _____ Date of Birth: _____

Reason for today's visit: _____

Allergies Are you allergic to any medications, anesthesia, or latex? ❑ Yes ❑ No If yes, please list below:

_____

Medications (Include herbal and OTC medications)
(Use back of sheet if necessary)

Are you on any blood thinners? ❑ Yes ❑ No
(Aspirin, warfarin, Plavix, etc.)

Name	Strength	Frequency

Medical History

Please indicate any of the following medical conditions you **have now** or have **ever had** in the past:

- ❑ Anemia
- ❑ Anxiety Attacks
- ❑ Arthritis
- ❑ Asthma
- ❑ Crohn's Disease
- ❑ Depression
- ❑ Diabetes
- ❑ Fainting Easily
- ❑ Heartburn / Reflux
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Heart Attack
- ❑ Other Heart Disease
- ❑ Hepatitis B or C
- ❑ HIV (AIDS)
- ❑ Immunosuppression
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Lung Disease
- ❑ Lupus
- ❑ Neurologic Disease
- ❑ Organ Transplant
- ❑ Platelet Disorder
- ❑ Seizures
- ❑ Stroke
- ❑ Thyroid Disorder
- ❑ Tuberculosis
- ❑ Ulcerative Colitis
- ❑ Artificial Heart Valve
- ❑ Artificial Joint
- ❑ Implantable Neurologic Device
- ❑ Pacemaker / Defibrillator
- ❑ Bleeds Easily
- ❑ Abnormal Scarring / Keloids

Skin Cancer (type): _____ Other Cancers (type): _____

Other Medical History: _____

Surgical & Hospitilzation History

Please list and surgeries or illnesses requiring hospitalization in the past.

Surgery or Illness	Date (Month/Year)

Height _____
Weight _____

Women Only
Are you pregnant? ❑ Yes ❑ No Due date: _____
Are you breastfeeding? ❑ Yes ❑ No

Family History

Check below for any family history of :

		Basal / Squamous Cell Carcinoma	Melanoma	Psoriasis	Acne	Eczema	Unknown
Mother	❑ Alive ❑ Deceased	❑	❑	❑	❑	❑	❑
Father	❑ Alive ❑ Deceased	❑	❑	❑	❑	❑	❑
Daughter(s)	❑ Alive ❑ Deceased ❑ N/A	❑	❑	❑	❑	❑	❑
Son(s)	❑ Alive ❑ Deceased ❑ N/A	❑	❑	❑	❑	❑	❑
Sister(s)	❑ Alive ❑ Deceased ❑ N/A	❑	❑	❑	❑	❑	❑
Brother(s)	❑ Alive ❑ Deceased ❑ N/A	❑	❑	❑	❑	❑	❑

Other important family history: _____

List all skin care products used: _____

Are you interested in learning about cosmetic services such as Botox, fillers, or laser treatments? ❑ Yes ❑ No

Social History

Do you drink alcohol? ❑ Yes ❑ No If yes, _____ drinks per day
Do you smoke? ❑ Yes ❑ No ❑ Former Smoker If yes, _____ packs per day
Do you use illicit drugs? ❑ Yes ❑ No If yes, what: _____

What is your occupation? _____ Hobbies?_____

_____ _____
Patient Signature Date Provider Signature Date