

MEDICAL INFORMATION

MEDICAL/SURGICAL HISTORY:

Do you have now or have you ever had:

	<u>Yes</u>	<u>No</u>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes/High blood sugar	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever/Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Stroke or Mini-Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack/Angina	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur/Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Kidney/bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent yeast infections	<input type="checkbox"/>	<input type="checkbox"/>
Bowel disease/Colitis/Crohn's	<input type="checkbox"/>	<input type="checkbox"/>
Frequent/Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>
Cancer other than skin	<input type="checkbox"/>	<input type="checkbox"/>
Radiation	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joint heart valve	<input type="checkbox"/>	<input type="checkbox"/>
Past surgery	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

If YES to any above, please explain:

CURRENT HEALTH:

	<u>Yes</u>	<u>No</u>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
How much?_____		
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
How much?_____		
Do you use drugs?	<input type="checkbox"/>	<input type="checkbox"/>
How much?_____		

MEDICATIONS:

List all medications you are taking, including any over-the-counter herbals or vitamins:

DERMATOLOGIC HISTORY:

Do you have now or have you ever had:

	<u>Yes</u>	<u>No</u>
Keloids/Abnormal scarring	<input type="checkbox"/>	<input type="checkbox"/>
Poor wound healing	<input type="checkbox"/>	<input type="checkbox"/>
Skin pigmentation problems	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to local anesthetic	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores/Herpes infections	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal ("Dysplastic") moles	<input type="checkbox"/>	<input type="checkbox"/>
Precancerous spots	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer – Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer – Basal Cell	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer – Squamous Cell	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal cold sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal sun sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Cosmetic surgery	<input type="checkbox"/>	<input type="checkbox"/>

If YES to any above, please explain:

ALLERGIES:

Are you allergic to any medications? Yes No

If so, please list: _____

FAMILY HISTORY:

	<u>Yes</u>	<u>No</u>
Do you have a family history of:	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer: Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Basal/Squamous Cell	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal ("Dysplastic") moles	<input type="checkbox"/>	<input type="checkbox"/>
Other skin disorder	<input type="checkbox"/>	<input type="checkbox"/>

FEMALES:

	<u>Yes</u>	<u>No</u>
Excess facial/body hair	<input type="checkbox"/>	<input type="checkbox"/>
Regular menstrual periods	<input type="checkbox"/>	<input type="checkbox"/>
How many pregnancies?_____		
How many miscarriages/abortions?_____		
Are you pregnant or nursing?	<input type="checkbox"/>	<input type="checkbox"/>
How many children do you have:_____		

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