MEDICAL INFORMATION

MEDICAL/SURGICAL HISTORY:

Do you have now or have you ever had:

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

If YES to any above, please explain:

_____

_____

_____

DERMATOLOGIC HISTORY:

Do you have now or have you ever had:

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

If YES to any above, please explain:

_____

_____

_____

_____

ALLERGIES:

Are you sensitive/allergic to any oral medications?_____

Please list:_____

_____

_____

CURRENT HEALTH:

	Yes	No
Do you smoke?	☐	☐
How much?_____		
Do you drink alcohol?	☐	☐
How much?_____		
Do you use drugs?	☐	☐
How much?_____		

MEDICATIONS:

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

_____

_____

_____

FAMILY HISTORY:

Do you have a family history of:		Yes	No
Allergies/Asthma		☐	☐
Skin Cancer :	Basal/Squamous	☐	☐
	Melanoma	☐	☐
Abnormal ("Dysplastic") moles		☐	☐
Other skin disorder		☐	☐

FEMALES:

	Yes	No
Excess facial/body hair	☐	☐
Regular menstral periods	☐	☐
Are you pregnant or nursing?	☐	☐

Names/ages of your children:

_____

_____

This office sends out newsletters and occasional promotions and announcements regarding new services or special offers. Please sign and date below to indicate if you would like to be included in these mailings.

Yes or **No** (please circle one)

_____ _____

Signature Date