

Health History

Name: _____

Date of birth: _____

List all medications (including prescriptions, over-the-counter meds, vitamins, and herbals):

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Have you been on Accutane in the past 12 months? _____

Do you take Aspirin, Plavix, Coumadin or Warfarin? _____

Are you ALLERGIC to any medication? If yes, please list: _____

Are you allergic to anything else? (please circle)

- | | |
|-----------------------------------|-------------|
| LATEX | Bandages |
| Food (specify _____) | Neosporin |
| Novacaine or other numbing agents | Other _____ |

Do you have, or have you had, any of the following medical conditions? If so, please circle:

- | | | |
|------------------------------------|------------------------------------|--------------------------------------|
| Seasonal allergies/hayfever | Asthma | |
| Emphysema | Diabetes | Thyroid disease |
| Rheumatic fever | Arthritis | Colon/bowel disease/colitis |
| Heart murmur | Artificial joints | Blood clots |
| Irregular heartbeat | Liver disease/hepatitis | Frequent Infections |
| Heart Attack | Stomach ulcers | Yeast infections when on antibiotics |
| Pacemaker/Defibrillator | Kidney disease | HIV or AIDS |
| Stroke/TIA | Dialysis | Blood Transfusion |
| Artificial heart valve | Bladder disease | Lupus |
| Anemia | Seizures | Recent fevers |
| Chills or night sweats | Recent weight loss or gain | Joint pain |
| Cancer–Type _____ | Polycystic ovarian syndrome (PCOS) | |
| High blood pressure (Hypertension) | Tuberculosis | |

No, I have not had any of the above conditions.

Do you have any other medical problems not mentioned above? If so, please list: _____

List any hospitalizations or surgeries (diagnosis and date) you have had within the past 2 years:

Have you ever had any of the following skin conditions? (please circle)

- | | | |
|---------------------------|---------------------|-----------------------------------|
| Eczema/dermatitis | Psoriasis | Herpes simplex virus (cold sores) |
| Skin cancer | Shingles | Hives |
| Basal cell skin cancer | Blistering sunburns | Keloid (thickened) scars |
| Squamous cell skin cancer | Easy bleeding | Abnormal (dysplastic) moles |
| Melanoma | Healing problems | Other skin condition: _____ |

None of the above

When exposed to sun, I: (circle one)

- | | |
|--------------------------------|-------------------------|
| Always burn and do not tan | Seldom burn, Tan easily |
| Always burn then tan a little | Never Burn, Always tan |
| Sometimes burn, tan moderately | |

Family history—Does your mom, dad, sibling, child, or grandparent have any of the following? (circle)

- | | | |
|--------|-----------|---|
| Eczema | Psoriasis | Atypical (dysplastic) moles |
| Lupus | Diabetes | Skin cancer (basal cell, squamous cell, melanoma) |

Social History

- Do you smoke? If yes, how much per day? _____
- Do you drink alcohol? If yes, how many drinks per day? _____
- Do you use IV drugs? If yes, what and how much? _____
- Do you wear sunscreen? _____
- Do you use OR have you used a tanning bed? _____ Frequency? _____

WOMEN: Are you pregnant, nursing, or trying to become pregnant? _____

How did you hear about us?

- My physician, Dr. _____
- My insurance company
- The yellow pages
- Friend or family member
- Web site
- Advertisement If so, what type...
Newspaper _____ Playbill _____
Magazine ___Whirl___ Pittsburgh Parent _____ Pittsburgh Magazine _____
- Other _____

Cosmetic Interest (optional)

General appearance concerns or areas of interest (please circle)

- | | | |
|-------------------|-------------------------|------------------------|
| Skin care advice | Facial redness | Sagging face/neck skin |
| Blotchy skin | Facial veins | Loose abdominal skin |
| Facial wrinkles | Brown spots/age spots | Cellulite |
| Facial fine lines | Drooping eyelids | Stretch marks |
| Thin lips | Puffy eyes | Facial hair |
| Acne | Dark circles under eyes | |

We provide cosmetic services. If interested, please circle those you may be interested in.

- | | |
|---|------------------------------|
| Botox Injections | Vbeam laser treatments |
| Facial Fillers (including Juvederm and Restylane) | Thermage for skin tightening |
| Chemical & Facial Peels | Microdermabrasion |
| Obagi, Avene, or Glytone Skincare products | Latisse for eyelashes |

Patient or Parent/Guardian signature: _____ Date _____

Reviewed by (physician signature): _____