

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

Food (specify _____)

Novocaine or other numbing agents

Bandages

Neosporin

Other _____

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

- | | | |
|-----------------------------|-----------------------------|---|
| Seasonal allergies/hayfever | Asthma | Tuberculosis |
| 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 while taking 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 | High blood pressure (Hypertension) |

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

Please circle one: When exposed to sun, I (Tan, burn then tan, or burn).

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? _____

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	Laser treatment of age spots
Facial Fillers (including Juvederm and Restylane)	Thermage for skin tightening
Chemical & Facial Peels	Revale Coffeeberry Skin Care Products
Laser Treatment of scars & stretch marks	Neova Skin Care Products

Patient or Parent/Guardian signature: _____

Date

Reviewed by (provider signature): _____