HEALTH HISTORY

**Name: _____ DOB: _____ Date: _____**

**Medical History (please circle)**

| | | |
|---|---|---|
| Anxiety | Depression | Hyperthyroidism |
| Arthritis | Diabetes | Hypothyroidism |
| Asthma | End Stage Renal Disease | Leukemia |
| Atrial fibrillation | GERD | Lung Cancer |
| Bone Marrow Transplant | Hearing loss | Lymphoma |
| BPH (enlarged prostate) | Hepatitis | Prostate Cancer |
| Breast Cancer | Hypertension (high blood pressure) | Radiation Treatment |
| Colon Cancer | HIV/AIDS | Seizures |
| COPD | High cholesterol | Stroke |
| Coronary Artery Disease | | |

Other _____

**Surgical History**

Please list all surgeries:_____
_____
_____

**Skin Disease History**

| | |
|---|---|
| Acne | Hay Fever/Allergies |
| Actinic Keratosis | Melanoma |
| Asthma | Poison Ivy |
| Basal Cell Skin Cancer | Precancerous Moles (Atypical/dysplastic) |
| Blistering Sunburns | Psoriasis |
| Dry Skin | Squamous Cell Skin Cancer |
| Eczema | NONE |
| Flaky or Itchy Scalp | |

Other _____

Do you wear sunscreen? Yes No

SPF _____

Do you tan in a tanning salon? Yes No

Have you ever tanned in a tanning salon? Yes No

Do you have a family history of melanoma? Yes No

If yes, which relative(s)? _____

**Medications** (Please list all current prescription and OTC medications, vitamins, and supplements)

| | | |
|---|---|---|
| 1._____ | 4._____ | 7._____ |
| 2._____ | 5._____ | 8._____ |
| 3._____ | 6._____ | 9._____ |

**Allergies** (Please list all allergies)

_____
_____

**Name: _____ DOB: _____ Date: _____**

**Social History** (Please circle)

Cigarette Smoking
- Never Smoked
- Quit/Former Smoker
- Current Smoker
  - _____ Packs Per Day

Alcohol Use
- Yes _____ drinks per day
- No

Occupation _____

**Family History** (Please circle)

Asthma Diabetes Bleeding disorders Eczema
Lupus Psoriasis Rheumatoid Arthritis Thyroid disease
Other _____

**Review of Systems:** *Have you recently had any of the following conditions? If yes, please provide additional details.*

| | | |
|---|---|---|
| Problems with healing | NO | YES_____ |
| Problems with scarring | NO | YES_____ |
| Rash | NO | YES_____ |
| Immunosuppression | NO | YES_____ |
| Hay fever | NO | YES_____ |
| Chest pain | NO | YES_____ |
| Fever or chills | NO | YES_____ |
| Night sweats | NO | YES_____ |
| Unintentional weight loss | NO | YES_____ |
| Thyroid problems | NO | YES_____ |
| Sore throat | NO | YES_____ |
| Blurry Vision | NO | YES_____ |
| Abdominal Pain | NO | YES_____ |
| Bloody stool | NO | YES_____ |
| Bloody urine | NO | YES_____ |
| Joint aches | NO | YES_____ |
| Muscle weakness | NO | YES_____ |
| Neck stiffness | NO | YES_____ |
| Headaches | NO | YES_____ |
| Seizures | NO | YES_____ |
| Cough | NO | YES_____ |
| Shortness of breath | NO | YES_____ |
| Wheezing | NO | YES_____ |
| Anxiety | NO | YES_____ |
| Depression | NO | YES_____ |

**Name: _____ DOB: _____ Date: _____**

**Special Alerts**

| | | |
|---|---|---|
| Do you take blood thinners | NO | YES |
| Do you have a history of MRSA? | NO | YES |
| Are you allergic to lidocaine? | NO | YES |
| Are you allergic to adhesives (such as bandages)? | NO | YES |
| Are you allergic to topical antibiotic ointments? | NO | YES |
| Do you have an artificial heart valve? | NO | YES |
| Have you had an artificial joint surgery within the past 2 years? | NO | YES |
| Do you have a defibrillator? | NO | YES |
| Do you have a pacemaker? | NO | YES |
| Do you need to pre-medicate prior to procedures? | NO | YES |
| Do you get a rapid heartbeat with epinephrine? | NO | YES |
| Do you have a history of cold sores? | NO | YES |
| WOMEN: Are you pregnant or trying to become pregnant? | NO | YES |
| Are you nursing/breast feeding? | NO | YES |

**Language**
English
Spanish
Other _____

**Race** (optional)
White
American Indian
Asian
Black or African American
Native Hawaiian or Pacific Islander
Other _____

**Ethnicity** (optional)
Hispanic or Latino
Non-Hispanic or Latino

**PHARMACY**

Local Pharmacy Name: _____
Phone: _____
Street: _____

Mail Order Pharmacy Name:_____
Phone: _____

**Cosmetic Interest**: *Please circle areas of concern or services of interest (optional)*

| | | | |
|---|---|---|---|
| Acne | Brown spots/Age spots | Chemical Peels | Facials |
| Facial wrinkles | Droopy or puffy eyelids | Botox | Thermage |
| Thin lips | Dark circles under eyes | Microdermabrasion | |
| Facial redness | Sagging skin of face/neck | Vbeam laser treatment | |
| Short eyelashes | Loose abdominal skin | Facial fillers – Juvederm, Restylane, Belotero | |

**Patient signature**: _____

**Reviewed by (Provider signature)**: _____