Medical History

Patient:_____ Age:_____ Today's date: _____

Reason for today's visit:_____

LIST All MEDICATIONS you are currently taking (including over the counter, vitamins, herbs, and supplements):

_____

_____

DRUG ALLERGIES Are you allergic to any medications? ☐ No ☐ Yes (Please indicate name of medications)

_____

Circle any other **allergies**: local anesthetics including dental anesthesia (Novacaine) rubber/latex, tape/bandages topical antibiotics

GENERAL MEDICAL HISTORY

Do you have a past or present history of any of the following?

	NO	YES	If yes explain		NO	YES	If yes explain
Asthma	☐	☐		Fever Blister/Cold Sores	☐	☐	
Eczema	☐	☐		HIV	☐	☐	
Seasonal Allergies	☐	☐		Hepatitis	☐	☐	
Lung Disease (Emphysema/COPD)	☐	☐		Cancer-Type: _____	☐	☐	
High Blood Pressure	☐	☐		Diabetes	☐	☐	
High Cholesterol	☐	☐		Kidney Disease	☐	☐	
Heart Attack	☐	☐		Gastrointestinal Disease	☐	☐	
Irregular Heartbeat/Heart Murmur	☐	☐		Seizures	☐	☐	
Pacemaker	☐	☐		Fainting	☐	☐	
Artificial Joint	☐	☐		Arthritis	☐	☐	
Lupus	☐	☐		Bruise or bleed easily	☐	☐	
Thyroid Disorder	☐	☐					

Other diseases/ conditions/ recent surgeries _____

SKIN HISTORY

When you are exposed to sun do you: ☐Tan only ☐Tan and burn ☐Burn How many times? _____

Have you ever had skin cancer? ☐NO ☐YES Basal Cell, Squamous Cell or Melanoma _____

Has anyone in your family had skin cancer ☐NO ☐YES If yes, who & type? _____

Do you have any difficulty in wound healing or form unsightly or unusual scars? ☐NO ☐YES

SOCIAL HISTORY

Do you drink alcohol? _____ drinks/day Do you smoke? _____ packs/day If yes, would you like information on how to quit smoking? _____

Have you used IV drugs?_____

Occupation: _____

IS IT OK TO LEAVE VOICEMAIL FOR LAB RESULTS? ☐NO ☐YES

PREFERRED MESSAGE PHONE # _____

Would you like more information on the cosmetic procedures we offer?
Yes ( ) No ( )

( ) Fotofacial RF (skin rejuvenation) ( ) Fillers ( ) Microdermabrasion
( ) Coolsculpting ( ) Botox ( ) Sclerotherapy
( ) Chemical peels ( )Tripllar ( ) Microneedling

_____
Signed By Patient or Guardian Date

_____
Signed by Physician Date

( ) Yes, I wish to be added to your monthly email specials

_____
E-mail Address