MEDICAL INFORMATION

I. MEDICAL / SURGICAL HISTORY:

Do you have or have you EVER had:

___Yes ___No High blood pressure
___Yes ___No Diabetes
___Yes ___No Stomach ulcers
___Yes ___No Tuberculosis
___Yes ___No Thyroid condition: ______________________
___Yes ___No Asthma
___Yes ___No Hayfever / seasonal allergies: _____________
___Yes ___No Sinus infections / problems
___Yes ___No Epilepsy
___Yes ___No Stroke or TIA
___Yes ___No Heart attack / Angina / Congestive Failure
___Yes ___No Pacemaker
___Yes ___No Heart murmur or Mitral valve prolapse
___Yes ___No Kidney / Bladder problem: _________________
___Yes ___No Prostate problem: _________________________
___Yes ___No Glaucoma
___Yes ___No Hepatitis / Liver disease; ___________________
___Yes ___No Fever blisters/Cold sores/Herpes infection
___Yes ___No Recurrent yeast infections: ________________
___Yes ___No Colitis / Bowel problems: ___________________
___Yes ___No Frequent/severe Headaches OR Migraines
___Yes ___No Artificial joint / heart valve: _______________
___Yes ___No Cancer: Type/ Date: _______________________
___Yes ___No Radiation / X-ray treatment: site____________
___Yes ___No Past surgery: ____________________________
____

___Yes ___No Are you pregnant OR nursing now?

II. DERMATOLOGIC HISTORY:

Do you have or have you EVER had:

___Yes ___No Dizziness / fainting tendency
___Yes ___No Keloids or abnormal scarring
___Yes ___No Abnormal cold sensitivity
___Yes ___No Poor wound healing
___Yes ___No Skin pigmentation problems
___Yes ___No Bleeding tendency
___Yes ___No Palpitations / Irregular heartbeat: ___________
___Yes ___No Reaction to local anesthesia: type ____________
___Yes ___No Eczema
___Yes ___No Psoriasis
___Yes ___No Dysplastic Nevus
___Yes ___No Precancerous spots / Solar keratoses
___Yes ___No Skin Cancer: (type/site/date/MD?)

____

___Yes ___No Cosmetic Surgery: (type/site/date/MD?)

____

____

III. CURRENT HEALTH:

Circle: Poor Fair Good Excellent

___Yes ___No Do you smoke? How much? ________________
___Yes ___No Do you drink alcohol? How much?___________
___Yes ___No Do you require oral antibiotics before dental work?

IV. MEDICATIONS:

List all medications that you are taking: ______________________

____

____

CIRCLE if you take: Aspirin, Coumadin, Antacids, Iron, Cortisone /Prednisone, Decongestants, Sedatives, Tranquilizers, Anti-histamines, or Oral Contraceptive Pills:
Specify: ____

V. ALLERGIES:

Are you sensitive or allergic to any ORAL MEDICATIONS?
___Yes ___No Specify: _________________________________

Are you sensitive or allergic to any foods? ___Yes ___No
To any skin products? ___ Yes ___ No
Which ones? ____

VI. FAMILY HISTORY:

Do you have a family history of:

___Yes ___No Basal Cell or Squamous Cell Carcinoma
___Yes ___No Malignant Melanoma
___Yes ___No Dysplastic Nevi
___Yes ___No Other skin disorder: What? _______________

____

___Yes ___No Have you ever seen a dermatologist?

Name: _________________________________ Date: _________

___ Yes ___No Would you like us to request any previous records, lab tests, biopsy reports for our records?
(***Please request and sign a record release form.***)

Signature: ____

Print Name: ____________________________ Date: ___________

(5/04)