MEDICAL INFORMATION (Do NOT leave blanks)

The following information is very important to your health. Please take the time to fill out this form fully and accurately.

Reason (s) for visit:_____

Symptoms (itching, burning, etc.):_____How Long?_____

What are you using for the problem?_____

List **skin** diseases you've had._____

List current medicines. _____List medication allergies._____

MEDICAL HISTORY

	Patient	Family Member (who?)	None
Excessive sun	□	□_____	□
Acne	□	□_____	□
Skin Cancer	□	□_____	□
Malignant Melanoma	□	□_____	□
Eczema	□	□_____	□
Psoriasis	□	□_____	□
Seborrhea (dandruff)	□	□_____	□
Large Scars or keloids	□	□_____	□
Asthma	□	□ _____	□
Sinus Problems	□	□ _____	□
Allergies	□	□_____	□
Bleeding Problems	□	□_____	□
Heart valve Disease	□	□_____	□
Heart attack	□	□_____	□
High blood pressure	□	□_____	□
Rheumatic Fever	□	□_____	□
Arthritis	□	□_____	□
Artificial joints	□	□_____	□
Connective Tissue Disease	□	□_____	□
Diabetes	□	□_____	□
Kidney Disease	□	□_____	□
Thyroid Disease	□	□_____	□
Stroke	□	□_____	□
Seizures	□	□_____	□
AIDS/HIV	□	□_____	□
Hepatitis	□	□_____	□
Liver Disease	□	□_____	□
Ulcers	□	□_____	□
Lung Disease	□	□_____	□
Cold sores/Fever blisters	□	□_____	□
Prostate Enlargement	□	□_____	□

List Other Disease/Cancers:_____

_____

List Prior Surgeries:_____

_____

SURGICAL & SKIN HISTORY

Ethnic/Racial Heritage:_____

List any artificial materials in your body(i.e. pacemaker, joints, etc.).

_____

Trouble with local anesthetics (i.e. Novacaine? □ Yes □No

Trouble with antibiotic ointment, tape, bandages? □ Yes □No

Need to take antibiotic before dental work/surgery? □ Yes □No

Radiation treatment in the past? □ Yes □ No

List prior cosmetic procedures (peels, laser, etc.)._____

_____

List problems with prior cosmetic procedures._____

_____

Is your skin? □Dry □Oily □Normal □Combination □Sensitive (check **ALL** that apply)

Pigmentation problems (i.e. after a burn, surgery, pregnancy)?

□ No □ Yes Explain:_____

SOCIAL HISTORY

Smoker	□ No	□ Yes
Alcohol Usage	□ No	□ Yes
Tanning Bed Usage	□ No	□ Yes
Regular exercise	□ No	□ Yes
Children	□ No	□ Yes (names & ages)

_____

Pets □ No □ Yes

_____

Average hours of sleep each night:_____

Weight:_____ Height:_____

Sexually Active □ No □ Yes

Specify any Birth Control used._____

1st day of last menstrual period:_____

Pregnant/Breast Feeding □ No □ Yes

List outdoor activities (i.e. gardening, fishing, sports, etc.)._____

_____

In the sun, do you use? □hats □ long sleeve shirts □ sunscreen □ sunglasses

Which best describes your pattern of tanning?

□ Burn easily; get red and never really tan

□ Burn easily; light tan with some difficulty

□ May burn initially but able to tan

□ Rarely burn; tan easily Natural Hair Color_____

□ Never burn; tan deeply Eye Color_____

Products used:	**Brand/ Type**
Body soaps	
Body lotions	
Facial soaps / cleansers	
Sunscreen / sunblock	How often?
Scrubs / masks / peels	
Shaving creams/cologne	
Perfumes	
Toothpaste / mouthwash	
Past acne treatments (i.e. Accutane, Clearasil, antibiotics)	

	Brand/Type
Other (i.e. prescription products)	
ALL makeup used	
List products that have irritated your skin (caused a reaction).	

The above information is true and correct. Signature:_____ Date:_____