DERMATOLOGY MEDICAL & COSMETIC HISTORY

Name _____ DOB:_____

Address:_____ Ph#:_____

What is the reason for your visit today? _____

How did you hear about us? _____ If by another patient, what is their name? _____

Did a physician refer you? If yes, whom _____ Primary Care Physician? _____

What **Pharmacy** do you use & address?_____

_____

Allergies / Current Medications

Are you allergic to Latex? ☐ YES ☐ NO

Are you allergic to Lidocaine? ☐ YES ☐ NO

Any vitamins / minerals – check all that you are taking:

☐ None
☐ Calcium supplement
☐ Chinese herbs
☐ Herbal supplements
☐ Multi-vitamin
☐ Vitamin B
☐ Fish oil
☐ Vitamin K
☐ Vitamin E
☐ Vitamin D
☐ Vitamin C

Are you interested in any Cosmetic Services?

Botox ☐ Fillers ☐ Facial Veins ☐
Brown Spot Correction ☐
Preventative Anti-Aging? ☐
Fat Reduction ☐
Facial Wrinkles / Folds ☐
Neck Laxity ☐ Skin Care Advice ☐
Collagen Stimulation ☐ Acne Scars ☐
Facial Jowling ☐
Skin Tightening ☐

Birth Control Method (if applicable) _____

Do you have any drug allergies? ☐ YES ☐ NO If yes, please list medication: _____

List all medications you are currently taking regular and occasionally (including prescriptions, over-the-counter, vitamins, and herbals):

_____ _____ _____

_____ _____ _____

Past Medical History

Have you had any previous hospitalizations? If yes, explain _____

_____

Please select what best describes your current general health:

☐Good General Health
☐Fair General Health
☐Poor General Health

Pregnant: ☐ YES ☐ NO

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Complete Past Medical History – Please mark any that apply:

☐Abnormal clotting
☐Abnormal menstruation
☐Acne
☐Actinic keratosis
☐Alopecia
☐Anemia
☐Anxiety
☐Arrhythmias
☐Arthritis
☐Asthma
☐Back pain
☐Basal Cell Carcinoma
Where _____
☐Bipolar disorder
☐Bleeding ulcers
☐Currently breast-feeding
☐Coronary artery disease
☐Cancer:
☐Breast
☐Colon
☐Skin
☐Liver
☐Lung
☐Congestive heart failure
☐Chronic edema
☐Cirrhosis of liver
☐Contact lens usage
☐Chronic obstruct pulmonary disease (COPD)
☐Cushing's disease
☐Depression
☐Dermatitis
☐Diabetes (diet controlled)
☐Diabetes (insulin depend.)
☐Diabetes (oral medication)
☐Deep vein thrombosis
☐Easy bleeding
☐Eczema
☐Emphysema
☐Genital herpes
☐Genital warts
☐GERD
☐Hair loss
☐Hearing loss
☐Heart attack (MI)
☐Hemophilia
☐Hepatitis A
☐Hepatitis B
☐Hepatitis C
☐Herpes zoster (shingles)
☐Herpes simplex (cold sores)
☐High blood pressure
☐HIV
☐High cholesterol
☐Hyperthyroid
☐Hypothyroid
☐Keloids
☐Lupus
☐Malignant melanoma
Where/ Year: _____/_____
☐Migraines
☐Mitral valve prolapsed
☐Moles – Precancerous_____
☐Moles- Dysplastic_____
☐Nipple discharge (left, right)
☐Pacemaker
☐Polycystic ovary syndrome
☐Pulmonary embolism
☐Psoriasis
☐Peripheral vascular disease
☐Rheumatoid arthritis
☐Renal failure
☐Rosacea
☐Squamous Cell Carcinoma
Where _____
☐Seasonal allergies
☐Slow healing
☐TB
☐Ulcers
☐Varicella (chicken pox)
☐Varicose veins
☐Vision loss
☐Warts

OTHER MEDICAL PROBLEMS (not listed above) _____

_____

Exposed to HIV in the past? ☐ YES ☐ NO

Do you have any artificial joints? ☐ YES ☐ NO Where: _____

Do you take antibiotics before dental work? ☐ YES ☐ NO Explain _____

Have you ever had dental anesthesia? ☐ YES ☐ NO Any problems with it? ☐ YES ☐ NO

Do you develop skin rashes to food? ☐ YES ☐ NO What happens?_____

Do you develop skin rashes to medications? ☐ YES ☐ NO What happens? _____

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Do you develop skin rashes from environmental factors? ☐ YES ☐ NO Explain _____

Do you have a seizure disorder? ☐ YES ☐ NO

Do you wear contact lenses? ☐ YES ☐ NO

Have you ever had a cold sore or fever blisters? ☐ YES ☐ NO

Have you been on Accutane in the past year? ☐ YES ☐ NO

Have you ever had skin rejuvenation, photo facials or a chemical peel? ☐ YES ☐ NO

Past Surgical History – Please Mark all that apply:

☐No Past Surgical History

FACIAL COSMETIC SURGERY
- ☐Hair transplant
- ☐Browlift
- ☐Upper blepharoplasty
- ☐Lower blepharoplasty
- ☐Facelift
- ☐Midface lift

HEENT SURGERY
- ☐Cleft lip
- ☐Cleft palate
- ☐Intracranial surgery
- ☐Facial fracture repair
- ☐Lasik surgery
- ☐RK surgery
- ☐Ptosis correction
- ☐Strabismus correction
- ☐Otoplasty
- ☐Rhinoplasty
- ☐Septoplasty
- ☐Thyroidectomy
- ☐Turbinate surgery
- ☐Tonsillectomy

BREAST SURGERY
- ☐Breast augmentation (☐saline, ☐ silicone)
- ☐Breast reduction
- ☐Mastopexy
- ☐Mastectomy (right, left)
- ☐Reconstruction (implant)
- ☐Reconstruction (TRAM)
- ☐Reconstruction (Lat Dorsi)

TRUNK SURGERY
- ☐Abdominoplasty
- ☐Back surgery
- ☐Rectus placation
- ☐Liposuction (☐abdomen, ☐chest, ☐ flanks, ☐hips, ☐back)

ABDOMINAL SURGERY
- ☐Appendectomy
- ☐Cholecystectomy
- ☐Gastric bypass
- ☐Gastric banding
- ☐Splenectomy
- ☐Bowel resection
- ☐Hernia repair

PELVIC SURGERY
- ☐Hysterectomy
- ☐BSO
- ☐C-section
- ☐Female genital surgery
- ☐Male genital surgery

EXTREMITY SURGERY
- ☐Hand surgery
- ☐Carpal tunnel release
- ☐Joint replacement
- ☐Brachioplasty
- ☐Liposuction (☐arm, ☐medial thigh, ☐lateral thigh, ☐calves)
- ☐Buttock lift
- ☐Body lift
- ☐Medial thigh lift
- ☐Varicose vein surgery

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Social History

Do you currently smoke? ☐YES ☐ NO If YES, how much? _____ # packs/day I did, but I quit _____-quitting date
Alcohol usage:
☐ Denies ☐ Weekly 1-2 ☐ Weekly 3 or more ☐ Daily 1-2 ☐ Daily 2-3 ☐ Heavy usage
Current or Past Tanning Bed usage:
☐ Denies ☐ Weekly ☐ Monthly ☐ Past Use
Do you use sunscreen?
☐ Daily ☐ When sunny ☐ Sometimes if sunny ☐ Rarely/never

What is your occupation? _____

What outdoor activities do you do (check all that apply)?

☐ Biking ☐ Golf ☐ Walking ☐ Boating ☐ Running ☐Other sports _____
☐ Fishing ☐ Gardening ☐ Tennis ☐ Swimming

Height: _____ Approximate Weight:_____

Family History

	Mark YES (if no, do not mark)	Family Member (mother, father, brother, sister, etc)	Notes
Allergies			
Arthritis			
Asthma			
Cancer			
Diabetes			
Eczema			
Heart disease			
High blood pressure			
Lung disease			
Psoriasis			
Tuberculosis			

Patient's Signature _____ Date _____

Parent or Guardian _____ Date _____