DERMATOLOGY INSTITUTE & LASER CENTER

Medical History

Date ____/_____/_____

Name _____Date of Birth ____/_____/_____ Age_____

- Are you allergic to any prescription or non-prescription (pill or rub on) medications?
  If yes, please give name(s). _____

  _____
- Do you have other allergies? Seasonal / Food / Other. If yes, please give name(s).

  _____

  _____
- List any medications you are currently taking (include vitamins, herbals, etc.).

  _____

  _____

Medical History

❑ Abnormal scarring or keloids	❑ Diabetes	❑ Liver Disease
❑ Acne	❑ Eczema	❑ Lupus
❑ Anemia	❑ Heart Attack	❑ Peripheral Vascular Disease
❑ Arthritis	❑ Hepatitis	❑ Psoriasis
❑ Asthma	❑ High Blood Pressure	❑ Seizure Disorder
❑ Blood Clots	❑ HIV+	❑ Stroke
❑ Congestive Heart Failure	❑ Irregular Heart Beat (arrhythmia)	❑ Thyroid Disorder
❑ Crohn's Disease / Ulcerative Colitis	❑ Joint Replacement	❑ Varicose Veins
❑ Depression	❑ Kidney Disease requiring Dialysis	❑ Other _____

Skin Cancer	❍ Y ❍ N	Specify:
Malignant Melanoma	❍ Y ❍ N	Specify:
Pre-cancerous Growths	❍ Y ❍ N	Specify:

- Do you ever take aspirin, ibuprofen (Motrin, Advil), naproxen sodium (Aleve, Naprosyn), vitamin E supplements, garlic, ginger, gingko or ginseng supplements? If yes, please list items and describe how often.

  _____

  _____

DERMATOLOGY INSTITUTE & LASER CENTER

Medical History (continued)

Medical History (continued)	
Develop rashes / reactions to bandages / tapes / antibiotic ointments	❍ Y ❍ N
Require antibiotics prior to dental procedures	❍ Y ❍ N
Tend to heal slowly or poorly	❍ Y ❍ N
Use a tanning booth / bed	❍ Y ❍ N
Wear contacts	❍ Y ❍ N
Reaction to local or general anesthesia	❍ Y ❍ N
Reaction to Epinephrine	❍ Y ❍ N

Past Surgical History	
Abnormal Heart Valve	❍ Y ❍ N
Artificial Heart Valve	❍ Y ❍ N
Defibrillator	❍ Y ❍ N
Dental Plates	❍ Y ❍ N
Pacemaker	❍ Y ❍ N
Artificial Joints _____	❍ Y ❍ N
Organ Transplant _____	❍ Y ❍ N

- List all major surgeries.

_____

_____

Skin Type	
Is your skin easily irritated?	❍ Y ❍ N
Do you tan easily?	❍ Y ❍ N
Do you use sunscreen / sunblock? If yes, how often_____ what SPF?_____	❍ Y ❍ N
Skin Type: ❍ Normal ❍ Oily ❍ Dry ❍ Combination	

- When exposed to the sun in the spring (first significant sun exposure of the warm season), do you?

❍ Always Burn Never Tan (I)

❍ Always Burn, Sometimes Tan (II)

❍ Sometimes Burn, Always Tan (III)

❍ Rarely Burn, Always Tan (IV)

❍ Never Burn, Always Tan (V)

DERMATOLOGY INSTITUTE & LASER CENTER

Medical History (continued)

Family History

Do any of your immediate family members (father, mother, siblings, child) have the following:

- ❑ Abnormal Moles
- ❑ Acne
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Blood Clots
- ❑ Cancer _____
- ❑ Diabetes
- ❑ Eczema (atopic dermatitis)
- ❑ Hair Loss
- ❑ Heart Disease
- ❑ Heart Attack
- ❑ High Cholesterol
- ❑ Lupus
- ❑ Malignant Melanoma
- ❑ Multiple Miscarriages
- ❑ Pre-Cancerous Growths
- ❑ Psoriasis
- ❑ Rheumatoid arthritis
- ❑ Rosacea
- ❑ Scarring
- ❑ Skin Cancer
- ❑ Stroke
- ❑ Thyroid Disorder
- ❑ Vitiligo
- ❑ Other_____ _____

Social History

Do you use tobacco? If yes, what type and how much? _____	❍ Y ❍ N
Do you drink alcohol? If yes, how much in one week? _____	❍ Y ❍ N
Do you use recreational drugs? If yes, what type and how much? _____	❍ Y ❍ N
Do you use IV drugs? If yes, what type and how much? _____	❍ Y ❍ N
What type of work do you do? _____	
Are you ❍ single, ❍ divorced, ❍ married, ❍ widowed?	

For Females Only

Date of your last menstrual period _____	
Are your periods regular?	❍ Y ❍ N
Are you menopausal?	❍ Y ❍ N
Are you pregnant?	❍ Y ❍ N
Are you breastfeeding?	❍ Y ❍ N
What type of contraception (if any) is used? _____	

DERMATOLOGY INSTITUTE & LASER CENTER

Medical History (continued)

Review of Symptoms

- ❑ Abdominal Pain
- ❑ Abnormal Sweating
- ❑ Anxiety
- ❑ Bloody Stool
- ❑ Chest Pain
- ❑ Cough
- ❑ Depression
- ❑ Dizziness
- ❑ Dry Eyes
- ❑ Dry Mouth
- ❑ Easy Bleeding
- ❑ Easy Bruising
- ❑ Excessive Fatigue
- ❑ Excessive Hunger
- ❑ Excessive Stress
- ❑ Excessive Thirst
- ❑ Excessive Urination
- ❑ Fever
- ❑ Fluid Retention
- ❑ Frequent Infections
- ❑ Hair Loss
- ❑ Headaches
- ❑ Heartburn
- ❑ Heat / Cold Intolerance
- ❑ Hemorrhoids
- ❑ Joint Pain or Swelling
- ❑ Joint Stiffness
- ❑ Leg Swelling
- ❑ Muscle Pain / Weakness
- ❑ Nausea / Vomiting
- ❑ Night Sweats
- ❑ Palpitations
- ❑ Penile Discharge
- ❑ Red Eyes
- ❑ Shortness of Breath
- ❑ Vaginal Discharge
- ❑ Vision Problems
- ❑ Weakness
- ❑ Weight Change
- ❑ Wheezing

- Are there any other symptoms you would like to name? If yes, please list.

_____

_____

_____ Date ___/___/___

Patient Signature

Initial _____

_____ Date ___/___/___

Legal Representative Signature

Initial _____

_____ Date ___/___/___

Physician Signature

Initial _____

Completed by ❑ Patient

❑ Medical Assistant _____