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MEDICAL HISTORY

Please circle all that apply:

Heart Disease or Arrhythmia	Diabetes	Peptic Ulcer Disease
Artificial Heart Valve	Thyroid Disease	Neurologic Disease
Heart Murmur	Malignancy	Lung Disease/Asthma
Pacemaker or ICD	Arthritis or Rheumatologic Disease	Kidney Disease
Bleeding Problems	Bell's Palsy	Liver Disease/Hepatitis
Peripheral Vascular Disease	Major Skin Infections or MRSA	Depression
High Cholesterol	Immune Deficiency/HIV	Keloid Formation

Do you smoke? _____ Packs per day/week _____ Do you drink alcohol? _____ Drinks per day/week _____

Female patients – Are you pregnant? _____

Have you had previous surgeries/procedures (including cosmetic), or associated complications? _____

If you had anesthesia, were there any issues or side effects? _____

List any other medical problems and provide additional information for "yes" answers: _____

_____

MEDICATIONS

Please list:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Any allergies to medications? Please list below (include reaction).

_____

_____

_____

_____

DERMATOLOGIC/COSMETIC HISTORY

1. Do you have a family history of skin cancer? Yes No If yes, who and what type? _____
2. Do you have a history of excessive sun exposure or sunburns? Yes No
3. Do you always burn when you are exposed to the sun? Yes No
4. Have you ever had a biopsy for a suspicious growth? Yes No
5. What is the primary reason for your visit? _____

_____

_____

Patient Name (print) _____ Signature _____ Date _____