

Patient Name _____ **Account #** _____ **Date** _____

Reason for today's visit _____

Who referred you to us? _____

MEDICAL HISTORY

Please check those medical conditions that apply to you (this information is kept confidential).

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Heart Murmur/Artificial heart valve | <input type="checkbox"/> Seizure Disorders | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis/Liver disease/Jaundice |
| <input type="checkbox"/> Gastrointestinal Problems | <input type="checkbox"/> Herpes Infections | <input type="checkbox"/> Blood Clotting Disorders |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma / Hayfever |
| <input type="checkbox"/> Poor Healing | <input type="checkbox"/> Breathing Difficulties | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Other (Please explain below) |
| <input type="checkbox"/> Endocrine or Hormone Problems | <input type="checkbox"/> Sexually Transmitted Diseases | |
| | <input type="checkbox"/> Tuberculosis | |
| | <input type="checkbox"/> Ulcers | |

Please explain any conditions checked above _____

Please list **ALL** medications you are currently taking (including aspirin, laxatives, birth control pills, vitamins, etc.) _____

ALLERGIES (list all known allergies to latex, metals, medications, jewelry, etc.) _____

Do you have a family history of skin cancer? If so what type? _____ Yes No

Have you ever had skin cancer? If so, what type? _____ Yes No

Do you have any changing or suspicious moles? _____ Yes No

(Unusual colors or bleeding)? _____

Are you pregnant or nursing? _____ Yes No

If no to pregnant are you trying to get pregnant? _____ Yes No

Have you had the influenza immunization this year? _____ Yes No

If yes, date of immunization? _____

Do you use tobacco? _____ Yes No

(Such as smokeless tobacco products, cigars, or cigarettes) If yes, how much? _____

Do you drink alcohol? _____ Yes No

Are you taking a blood thinner, like Coumadin or aspirin? _____ Yes No

If so, which? _____

Do you have a heart problem or artificial joint that requires you to take antibiotics before a surgical or dental procedure? _____ Yes No

Do you have a pacemaker? _____ Yes No

Are you interested in Hair Transplantation? _____ Yes No

Thank you for your time in completing your medical history. This helps your doctor to keep current with your health. It is our goal to provide you the best care possible.

Patient / Guarantor Signature * _____ Date _____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

Are you interested in learning about our Cosmetic Services? If no, please return this form to our receptionist. If yes, please continue onto the following questions. Thank you.

Are you interested in cosmetic procedures that improve the appearance of fine lines, wrinkles and discoloration? _____ Yes No

Are you interested in meeting with our cosmetic consultant regarding skin care and skin regimentation? _____ Yes No

Are you interested in treatment of facial blood vessels or leg veins using LASER or Sclerotherapy? _____ Yes No

Are you interested in LASER hair removal? _____ Yes No