

Patient Health History Form

Name: _____

Date: _____

Reason for appointment: _____

Medication Allergies (circle) **NO YES** If Yes, list: _____

Are you allergic to anything else? (circle) Latex, Bandages, Novocain or other numbing agents,
Food (specify) _____, Other _____

Do you take Aspirin, Plavix, or Coumadin? (circle) **NO YES**

Do you take prophylactic antibiotics for dental surgery? (circle) **NO YES**

Current Medications (including prescriptions, over the counter, vitamins, or herbals):

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Do you have, or have you had, any of the following medical conditions? **(please circle)**

- | | | | | |
|---------------------|------------|------------------|---------------|------------------------|
| Seasonal allergies | Asthma | Tuberculosis | Emphysema | Diabetes |
| Thyroid Disease | Arthritis | Heart Murmur | Heart Attack | Blood Clots |
| Colon/Bowel Disease | Stroke/TIA | Bladder Disease | Pacemaker | Blood Transfusion |
| Irregular Heartbeat | Dialysis | Kidney Disease | Liver Disease | Artificial Joints |
| Rheumatic Fever | Lupus | Stomach Ulcers | HIV or AIDS | Artificial Heart Valve |
| Frequent Infections | Anemia | Weight Loss/Gain | Seizures | High blood Pressure |

Have you ever had any of the following skin conditions? **(please circle)**

- | | | |
|---------------------|-------------------|-----------------------------------|
| Eczema/Dermatitis | Psoriasis | Herpes Simplex Virus (cold sores) |
| Skin Cancer | Shingles | Basal Cell Skin Cancer |
| Blistering Sunburns | Hives | Keloid (thickened) Scars |
| Easy Bleeding | Melanoma | Squamous Cell Skin Cancer |
| Healing Problems | Actinic Keratosis | Abnormal (dysplastic) Moles |

Family History **(please circle)** Melanoma Other Skin Cancer

Social History **(please circle)** Smoke Drink Alcohol Pregnant (if applicable)
Wear Sunscreen Use Tanning Beds

Would you be interested in learning more about cosmetic procedures to enhance your skin?
(please circle) NO YES If yes, what areas interest you? **(please circle below)**

- | | | |
|--------------------------------|--------------------------|--------------------|
| Wrinkle/Facial Line Reduction | Leg Vein Treatment | Hair Reduction |
| General Complexion Improvement | Facial Redness Treatment | Age Spots/Freckles |