MEDICAL HISTORY

Name:_____DOB:_____AGE:_____SEX:_____

Primary Care Physician: _____
Address: _____
_____
Phone number: _____

Allergies to Food or Medication:
1:_____ 2: _____ 3: _____

Current Medications: (Include Non-Prescription Medications and Birth Control Pills):
1:_____ 4: _____
2:_____ 5: _____
3: _____ 6: _____

Do you have or have you had (please circle) :
In the past:

1. Skin Disease	Yes	No
A: Eczema	Yes	No
B: Psoriasis	Yes	No
C: Skin Cancer	Yes	No
D: Acne	Yes	No
E: Rosacea	Yes	No
F: Large scars or Keloids	Yes	No
2. Diabetes	Yes	No
3. High blood pressure	Yes	No
4. Low blood pressure	Yes	No
5. Heart problems	Yes	No
6. Artificial joints or valves	Yes	No
7. Hay fever	Yes	No
8. Asthma	Yes	No
9. Kidney problems	Yes	No
10. Liver Disease or Hepatitis	Yes	No
11. Cancer (Other than skin)	Yes	No
12. Seizures	Yes	No
13. Bleeding / Clotting Disorder	Yes	No
14. Autoimmune Disease (Lupus,MS)	Yes	No
15. Psychiatric Illness	Yes	No
16. Pacemaker or Defibrillator	Yes	No

List surgeries (operations)

1: _____

2: _____

3: _____

4: _____

5: _____

Have you had surgery in the past 3 months? Yes No

Have you had surgery for skin cancer?
Yes No

Any Medical Conditions not listed above? _____
_____
_____
_____

(CONTINUED ON BACK)

Have you had any of the following conditions:
In the past 3 months ?
(circle)

1. Breathing Problems: Yes No
2. Persistent Cough: Yes No
3. Shortness of Breath: Yes No
4. Angina/Chest pain: Yes No
5. Bloody or Dark Stools: Yes No
6. Diarrhea: Yes No
7. Nausea or Vomiting: Yes No
8. Painful Urination: Yes No
9. Blood in urine: Yes No
10. Abdominal Pain: Yes No
11. Arthritis: Yes No
12. Fever: Yes No
13. Persistent Headache: Yes No
14. Visual Changes: Yes No
15. Fatigue: Yes No
16. Muscle Weakness: Yes No
17. Anemia: Yes No
18. Thyroid Problems: Yes No
19. Dizziness or Passed Out: Yes No

Other (Please explain):

_____
_____
_____
_____
_____

Do you have a family history of:
(circle)

1. Eczema Yes No
2. Hay Fever Yes No
3. Psoriasis Yes No
4. Skin Cancer Yes No
   Type:_____
5. Breast Cancer Yes No
6. Clotting Disorder Yes No
7. Other: (list)_____
   _____
   _____

Do you smoke: Yes No
A. How much:_____
B. How long:_____

Do you drink alcohol: Yes No
If yes, how much:_____

Occupation:_____

For Women:
1. Age of first period_____
2. Are your periods regular: _____
3. Date of last period:_____
4. Does your acne flare up around your periods? Yes No N/A
5. Have you ever been pregnant?___
6. How many times have you been Pregnant? _____
7. Are you currently pregnant?_____
8. Age of Menopause _____

_____ _____

Patient/Parent Signature **Date** **Physician Signature** **Date**