Past Medical History

Name:_____ DOB:___/___/___ Date:___/____/____

Are you pregnant? Y___ N___ **Are you nursing? Y___ N___**

Are you planning on becoming pregnant? Y___ N___

Are you currently taking ACCUTANE or have you taken this in the last 6 months? Y___ N___

Past Personal Medical History: (please circle all that apply)

Anemia	Cancer	Heart Disease	HIV/AIDS
Arthritis	Chronic Cough	Heart Valve Problems	Migraines
Artificial Joint	Cold Sores	Heart Murmur	Multiple Sclerosis
Autoimmune Disorder	Colitis	Irregular Heart Beat	Plebitis
Bleeding Disorder	Connective Tissue Disorder	Pacemaker	Seizures
Blood Clots	Diabetes	Defibrillator	Stroke
Breast Cancer	Dialysis	Herpes Simplex	Thyroid Disorder
Bronchitis	Depression	Hepatitis B or C	Tuberculosis
Burns	Fibromyalgia	High Blood Pressure	Ulcers
Raynaud's Disease	Metal Implants	Other (explain):	

Past Personal Skin History: (please circle all that apply)

Undiagnosed Skin Lesions	Connective Tissue Disorder	Melanoma	Shingles
Actinic Keratosis	Skin Infections	Psoriasis	Eczema
Basal Cell Cancer	Squamous Cell Canver	Lupus	Pigment Disorder
Keloid Scarring	Other (explain):		

Have you ever seen a dermatologist or plastic surgeon for your skin? Y___ N ___

If yes, explain:_____

Adopted	Diabetes	Heart Disease	Autoimmune Disorders
Skin Disease	Cancer	Melanoma	Stroke
High Blood Pressure	Other (explain):		

Family History: (please circle all that apply):

Review of Systems: (please circle if you currently or recently have had any of the following)

Poor General Health	Headache	Suspicious Moles	Flushing
Swollen Lymph Nodes	Chest Pain	Swollen Legs/Feet	Itching
Heat/Cold Intolerance	Circulation Problems	Numbness	Easy Bleeding/Bruising
Fever	Non-healing Sores	Rashes	Fainting
Undiagnosed Problems	Other (explain):		

Prescription/OTC Medications (please list all medications, dosages, and instructions for use)

_____ _____

_____ _____

Topical Medications (please circle all that apply):

Retin A Renova Refissa Tazorac Differin Hydroquinone Topical Hormones
Other:_____

Medication Allergy and/or Reaction

_____ _____ Latex allergy? Y___N___

Iodine allergy? Y____ N____

Previous Surgeries (please list procedure and date):

_____ _____

_____ _____

Patient Signature: _____ Date: _____

Reviewed By:_____ Date: _____