PATIENT MEDICAL HISTORY FORM

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This form is a part of your permanent medical record. Thank you for taking the time to complete it as thoroughly and accurately as possible.

NAME (Last, First, MI) ____

DATE OF VISIT ____________________

REASON(S) FOR TODAY'S VISIT (Please limit to 3 complaints)

1. ____
2. ____
3. ____

❑ I would like to discuss treatment options for the following cosmetic issues :

[ ] wrinkles [ ] sun damage/sunspots [ ] hair removal [ ] spider veins/broken blood vessels [ ] uneven skin texture/tone

MEDICATIONS

Please list all current medications, including topical creams, vitamins, OTC's, and herbal supplements:

MEDICAL HISTORY

Please list all current/chronic medical conditions:

1.____
2.____
3.____
4.____
5.____

Have you ever had skin cancer or atypical moles? **YES** **NO**

If yes, what type ____

Do you require antibiotics prior to surgery or dental work? **YES** **NO**
Are you nursing? **YES** **NO**
Are you pregnant? **YES** **NO**
If yes, due date _______________
Are you trying to get pregnant? **YES** **NO**

ALLERGIES

Please list any known drug allergies:

1.______________________________ 4.______________________________
2.______________________________ 5.______________________________
3.______________________________ 6.______________________________

Are you allergic to latex? **YES** **NO**
Are you allergic to any local anesthetics? **YES** **NO**

FAMILY HISTORY

Please list any medical conditions (including but not limited to skin conditions, such as non-melanoma and melanoma skin cancers, psoriasis, eczema) of the following family members:

Father ______________________________
Mother ______________________________
Siblings ______________________________
Children ______________________________
Paternal Grandfather ______________________________
Paternal Grandmother ______________________________
Maternal Grandfather ______________________________
Maternal Grandmother ______________________________

SOCIAL HISTORY

Please be honest. This can affect medication selection and dosing.

Do you smoke? **YES** **NO**
If yes, how often and how much? ______________________________

Do you drink alcohol? **YES** **NO**
If yes, how often and how much? ______________________________

Do you use recreational drugs? **YES** **NO**
If yes, how often and how much? ______________________________

Do you use sunscreen? **YES** **SOMETIMES** **NO**

Do you have a history of extensive sun exposure or blistering sunburns? **YES** **NO**

Do you have a history of tanning bed use? **YES** **NO**

What is your occupation? ______________________________

REVIEW OF SYMPTOMS

Please check any of the following that you have experienced in the past 6 months:

GENERAL
- ❑ weight gain / loss
- ❑ loss of appetite
- ❑ fever / chills
- ❑ weakness
- ❑ night sweats

DERMATOLOGY
- ❑ rash
- ❑ lumps
- ❑ dry/sensitive skin
- ❑ hives
- ❑ suspicious moles
- ❑ suspicious lesions
- ❑ jaundice
- ❑ acne
- ❑ itching
- ❑ hair loss

EAR/NOSE/THROAT
- ❑ congestion
- ❑ nosebleed
- ❑ change in voice
- ❑ sore throat
- ❑ difficulty swallowing

ALLERGY
- ❑ runny nose
- ❑ scratchy throat
- ❑ itchy eyes
- ❑ sinus congestion
- ❑ sneezing

CARDIOLOGY
- ❑ chest pain
- ❑ palpitations
- ❑ leg swelling

MUSCULOSKELETAL
- ❑ joint stiffness
- ❑ leg cramps
- ❑ joint pain
- ❑ joint swelling
- ❑ back pain
- ❑ neck pain
- ❑ muscle aches

RESPIRATORY
- ❑ shortness of breath
- ❑ chest tightness
- ❑ cough
- ❑ wheezing
- ❑ congestion

PSYCHOLOGY
- ❑ depression
- ❑ high stress level
- ❑ suicidal thinking
- ❑ eating disorder
- ❑ mental or physical abuse
- ❑ mood swings
- ❑ obsessive - compulsive tendencies

ENDOCRINE
- ❑ excessive sweating
- ❑ excessive thirst
- ❑ excessive urination
- ❑ heat intolerance
- ❑ cold intolerance

BLOOD/LYMPH
- ❑ swollen glands
- ❑ fatigue
- ❑ varicose veins
- ❑ easy bruising

OPTHALMOLOGY
- ❑ decreased vision
- ❑ eye irritation
- ❑ eye drainage
- ❑ blurry vision

NEUROLOGY
- ❑ headache
- ❑ tingling/numbness
- ❑ seizures
- ❑ dizziness

GASTROENTEROLOGY
- ❑ nausea
- ❑ vomiting
- ❑ heartburn
- ❑ abdominal pain
- ❑ change in bowel habits

UROLOGY
- ❑ difficulty urinating
- ❑ blood in urine
- ❑ leaking urine

Patient Signature ______________________________ Date ____________