COMPREHENSIVE DERMATOLOGY CENTER

MEDICAL HISTORY

NAME: ____________________________ TODAY'S DATE: ______________________________

REASON FOR VISIT: ____

DURATION OF PROBLEM:____

PRIOR TREATMENT OF THE PROBLEM:____

LIST MEDICAL CONDITIONS YOU HAVE RECEIVED TREATMENT FOR:______________________

____

LIST CURRENT MEDICATIONS (including OTCs, Vitamins, and Herbal supplements):

____

____

DRUG ALLERGIES:____

DO YOU DRINK ALCOHOL: YES ☐ NO ☐ DO YOU SMOKE: YES ☐ NO ☐

DO OTHER FAMILY MEMBERS HAVE SIMILAR SKIN PROBLEM: YES ☐ NO ☐

HAS ANYONE IN YOUR FAMILY EVER HAD: Skin cancer ☐ Diabetes ☐ Psoriasis ☐ Eczema ☐

DO ANY OF THE FOLLOWING APPLY TO YOU (CHECK ALL THAT APPLY)

- ☐ Recent weight loss, weakness
- ☐ Fever, chills, night sweats
- ☐ HIV positive, AIDS
- ☐ Use illicit drugs
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Pacemaker or defibrillator
- ☐ Artificial heart valve
- ☐ Problems with your eyes
- ☐ Hearing difficulty
- ☐ Artificial joints
- ☐ Joint pain/arthritis
- ☐ Take asprin or blood thinner
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Hepatitis
- ☐ Stomach problem
- ☐ Painful urination
- ☐ Kidney disease
- ☐ Muscle weakness
- ☐ Bone problems
- ☐ Nerve problems
- ☐ Mouth or throat sore
- ☐ Asthma
- ☐ Glaucoma
- ☐ Radiation therapy
- ☐ Blood transfusion
- ☐ Keloids
- ☐ History of skin cancer
- ☐ Accutane therapy
- ☐ Depression
- ☐ Cancer
- ☐ Anemia
- ☐ Prior surgeries
- ☐ Bleed easily
- ☐ Breathing problems

FEMALE PATIENTS ONLY Irregular periods ☐ On birth control pills ☐ Pregnant now ☐ Nursing ☐

PLEASE CIRCLE IF YOU WOULD LIKE TO KNOW MORE ABOUT THE FOLLOWING:

Botox Restylane Radiesse Microdermabrason & Facials Chemical Peels Scar Revision

Wrinkle Treatment Brown Spots Dark Circle Excessive Sweating Skin Care Products