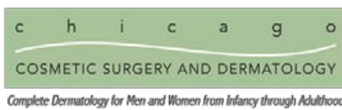

Medical History Form

Name:_________________________________ Age:______ Date of Birth:_____________ Today's Date:___________
Insurance company:____
Current Medications:____
Pharmacy Name and Address: __________________________________Pharmacy Phone:______________________
Facial creams used:____
Referred By:____

Drug Allergies: □ None □ Penicillin □ Sulfa □ Tetracycline □ Doxycycline □ Codeine □ Other:_______________________

Past History:
Past Cosmetic treatments: □ Botox □ Restylane □ Perlane □ Juvederm □ Radiesse □ Sculptra □Collagen
□ Liposuction □ Facelift □ Eyelid surgery □ Laser, Type:_________________ □Other_______________________

Past Surgeries: (Type and Date): ____

Review of Systems:
Skin: □ normal □ psoriasis □ eczema □ sunburns □ other:_________________________
□ **Skin Cancer:** □ melanoma □ squamous cell □ basal cell Date:______________

Constitutional: □ normal □ weight loss □ weight gain □ fever

Cardiovascular: □ normal □ artificial heart valve □ high blood pressure □ heart attack □ pacemaker
□ mitral valve prolapse □ other____________________________________

Ears/Eyes/Nose: □ normal □ glaucoma □ glasses/contacts □ other_____________________

Endocrine: □ normal □ diabetes □ thyroid disease □ other___________________________

Gastrointestinal: □ normal □ reflux □ Crohn's □ inflammatory bowel □ high cholesterol
□ other____

Hematologic/Lymphatic: □ normal □ anemia □ bleeding problems □ other_______________

Infections: □ none □ hepatitis □ HIV □ other____________________________________

Musculoskeletal: □ normal □ arthritis □ artificial joint □other___________________________

Neurological: □ normal □ stroke □ seizures □ fainting □ other______________________

Respiratory: □ normal □ asthma □ emphysema □ other_____________________________

Psychiatric: □ normal □ depression □ anxiety attacks □ other__________________________

Family History:
□ eczema, ______________ relationship □ psoriasis, ___________ relationship
□ melanoma ,____________ relationship □ other , ______________ relationship

Social History: marital status: □ Single □ Married □ Divorced □ Widowed
occupation:____
smoking: □ no □ former □ yes, # of packs per day_________
alcohol: □ no □ social/occasional □ recovering alcoholic

Reason for appointment:____

How long have you had the problem:___________**days / weeks / months / years**

Any Treatment?:____