

Today's Date: ___/___/___ Name: _____

Updated: ___/___/___ Date of Birth: ___/___/___ Age: _____

Updated: ___/___/___ Gender: M F Height: _____ Weight: _____

Primary Care Physician: _____
 Address: _____
 Referred By: _____

Current Medications

Allergies (Medication / Food)

Are You Taking...

- Aspirin
 - Blood Thinners
 - Immunosuppressants
 - NSAIDS (ibuprofen/naproxen/Celebrex, etc)
 - Vitamins / Supplements (List)
- _____

Past Medical History (Please check all that apply)

Skin Disease Yes / No

- Acne
- Psoriasis
- Eczema
- Lupus
- Other: _____
- Skin Cancer
- Basal Cell
- Squamous Cell
- Melanoma

Diabetes Yes / No

Heart Disease Yes / No

- Failure
- Valve Replacement
- Mitral Valve Prolapse
- Pacemaker
- Defibrillator

Hematologic Yes/No

- Anemia
- Clotting Disorder
- Leukemia
- Lymphoma

Hypertension (High Blood Pressure) Yes / No

Arthritis Yes / No

- Osteoporosis
- Psoriatic
- Rheumatoid
- Joint Replacement

Respiratory Disease Yes / No

Kidney Disease Yes / No

- Dialysis
- Transplant

Infectious Disease Yes / No

- Tuberculosis
- Hepatitis
- HIV / AIDS

Stomach / Colon Disease Yes / No

Neurological Disease Yes / No

- Multiple Sclerosis
- Faint Easily
- Seizures

Cancer (Other Than Skin) Yes / No

- Type: _____

Female Gynecological History

- Currently Taking Birth Control Pills
- Currently Pregnant
- Hysterectomy
- Menopause
- Normal Menstruation Cycles

Family History

- Skin Cancer
- Eczema
- Acne
- Psoriasis
- Diabetes
- Inherited Skin Disorders
- Neurological Disease

Social History

Occupation: _____

Smoke? Yes / No

Alcohol Consumption: Daily / Social / None

Sun Exposure

- Hours Per Day in Sun: _____
- Sunscreen/Sunblock Usage:
 - Always
 - Sometimes
 - Never

All Major Surgeries / Inherited Skin Disorders
