PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY FORM

Name_____ **Date**_____
Age_____ **Sex**_____ **How did you hear about us?**_____

Reason for today's visit:

Any prior treatments for this problem?

List any prior cosmetic procedures:
Any complications or problems?

Do you exercise regularly? ☐ **no** ☐ **yes; What is your regular routine?**

PLEASE LIST ALL MEDICATIONS, DOSAGES, & FREQUENCY (Including vitamins, herbs and supplements)

MEDICATION ALLERGIES: ☐ **NONE** **List:**

Check ALL that apply regarding your overall health and *add any other medical problems*:

CARDIOVASCULAR:
☐ normal
☐ artificial heart valve
☐ pacemaker
☐ high blood pressure
☐ heart attack (when?)
☐ high cholesterol
☐ bypass or other surgery
☐ mitral valve prolapse
☐ other heart problem

GASTROINTESTINAL:
☐ normal
☐ stomach ulcer
☐ colitis
☐ irritable bowel syndrome

NEUROLOGICAL:
☐ normal
☐ stroke
☐ seizure disorder
☐ Alzheimer's

PSYCHIATRIC:
☐ normal
☐ depression
☐ anxiety disorder
☐ other:

BLOOD/LYMPH:
☐ normal
☐ enlarged lymph glands
☐ bleeding problems

RESPIRATORY:
☐ normal
☐ emphysema
☐ asthma

ENDOCRINE:
☐ normal
☐ diabetes
☐ thyroid problem

SKIN:
☐ normal
☐ keloids
☐ poor/slow healing

GENERAL:
☐ normal
☐ fever
☐ weight loss

INFECTIONS:
☐ none
☐ hepatitis
☐ HIV or AIDS
☐ TB (tuberculosis)

MUSCULOSKELETAL:
☐ normal
☐ arthritis
☐ artificial joint
☐ fibromyalgia

HEAD/NECK:
☐ normal
☐ hearing aid
☐ glaucoma
☐ plastic surgery:

OTHER MEDICAL PROBLEMS:_____
_____
Previous skin cancer: _____
MAJOR ILLNESSES OR HOSPITALIZATIONS: ☐ **none LIST:**_____
_____
FAMILY HISTORY: ☐ **melanoma** ☐ **other skin cancer (basal cell or squamous cell)** ☐ **bleeding problems**
☐ **other major medical problems:**
Occupation: _____ **Marital Status:** ☐ **S** ☐ **M** ☐ **D** ☐ **W**
Do you wear: ☐ **dentures** ☐ **glasses** ☐ **contact lenses**
Smoking: ☐ **no** ☐ **former** ☐ **yes; how many packs/day?** _____
Alcohol: ☐ **no** ☐ **social/occasional drinking only**
Alcohol or drug problems/addictions: ☐ **no** ☐ **describe:** _____