Skin Care Experts
Medical History Form

Patient Name: _____ **DOB**: _____ **Today's Date**: _____

Email Address: _____

Please list the phone number you prefer to be called with test results: _____

Primary or Referring Physician: _____

Preferred Pharmacy: _____

Occupation: _____

Past Medical History:

Do you now have, or have you ever been diagnosed with any of the following conditions: (Check is Yes)

□ Anxiety
□ Arthritis
□ Asthma
□ Atrial fibrillation
□ Benign Prostate enlargement
□ Bone Marrow Transplant
□ Breast Cancer
□ Colon Cancer
□ COPD
□ Coronary artery disease
□ Depression
□ Diabetes
□ End stage kidney disease
□ GERD/Acid reflux
□ Hearing loss
□ Hepatitis B
□ Hepatitis C
□ High blood pressure
□ HIV/AIDS
□ High cholesterol
□ Hyperthyroid (high)
□ Hypothyroid (low)
□ Leukemia
□ Lung Cancer
□ Lymphoma
□ Prostate cancer (males)
□ Radiation treatment
□ Seizures
□ Stroke
□ **None of these**

Other medical problems not listed above:

_____

_____

List any major surgeries:

_____

_____

Skin Cancer History: Have you ever had skin cancer? **Yes** or **No**
If yes, Circle what type(s): **Basal Cell** **Squamous Cell** **Melanoma** **Not Sure**
Do you use Sunscreen? **Yes** or **No** **Spf**: _____
Have you ever used a tanning bed? **Yes** or **No**
Do any of your blood relatives have melanoma? **Yes** Or **No**
If yes, what is their relationship to you? _____

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Medications:
Current Medications:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies:
Please list any allergies you have:

_____ _____

_____ _____

_____ _____

_____ _____

Social History: Do you drink alcohol? **Yes** or **No** If yes, _____ drinks pre day/week
Do you smoke? **Yes** **Quit** **No** If yes, _____ packs per day
Would you be interested in cosmetic procedures today or in the future? **Yes** or **No**

Review of systems:
Do you have problems with healing? **Yes** or **No** or excessive scarring (keloid)? **Yes** or **No**
Do you have any problems with your immune system? **Yes** or **No**
If yes, Please Specify_____

Alerts: (Circle yes or no)
Have you ever had a bad reaction to local anesthesia? **Yes** or **No**
Are you allergic to Adhesive? **Yes** or **No**
Are you allergic to topical antibiotic ointments? **Yes** or **No**
Are you on a blood thinner (including Aspirin)? **Yes** or **No**
Do you have a defibrillator? **Yes** or **No**
Do you have a pacemaker? **Yes** or **No**
Have you been told to take antibiotics prior to dental or surgical procedures? **Yes** or **No**
Do you get a rapid heartbeat with epinephrine? **Yes** or **No**
Are you pregnant, planning pregnancy or currently breast feeding? **Yes** or **No**