Medical Information

(Please Print)

I Medical History

Do you have or have you ever had:

	Yes	No
Heart Attack / Angina	☐	☐
Heart Murmur	☐	☐
Artificial Heart Valve / Joint	☐	☐
High Blood Pressure	☐	☐
Dizziness / Fainting Tendency	☐	☐
Pacemaker	☐	☐
Frequent or Severe Headaches	☐	☐
Epilepsy / Stroke	☐	☐
Bleeding Problems	☐	☐
Anemia or Blood Disorder	☐	☐
Abnormal Response to Cold	☐	☐
Poor Wound Healing	☐	☐
Skin Pigment Problems	☐	☐
Keloids or Abnormal Scars	☐	☐
Diabetes	☐	☐
Thyroid Condition	☐	☐
Kidney or Bladder Problems	☐	☐
Hepatitis / Liver Disease	☐	☐
Aids / HIV Positivity	☐	☐
Fever Blisters / Cold Sores	☐	☐
Tuberculosis	☐	☐
Stomach Ulcers	☐	☐
Sinus or Hay fever	☐	☐
Glaucoma	☐	☐
Asthma	☐	☐
Depression / Mental Illness	☐	☐
Cancer: Type? ___________________	☐	☐
Radiation Treatment: Site? __________	☐	☐
Are You Pregnant? Nursing?	☐	☐
Under Medical Treatment Now?	☐	☐

II Medications

Are you sensitive or allergic to:

	Yes	No
Penicillin	☐	☐
Local Anesthetic	☐	☐
General Anesthetic	☐	☐
Any Other Medication or Foods	☐	☐

If So, What? ____________________________

____

Are You Taking:

	Yes	No
Aspirin	☐	☐
Cortisone, Prednisone, Steroids	☐	☐
Anti coagulates / Blood Thinners	☐	☐
Tranquilizers or Sedatives	☐	☐
Insulin	☐	☐
Any Other Medications or Drugs	☐	☐

If So, Specify ___________________________

____

III Family History

	Yes	No
Skin Cancer	☐	☐
Dysplastic Nevi (Moles)	☐	☐
Other Skin Disorder	☐	☐

If So, Specify ___________________________

____

IV Past Medical History

	Type or Name	Year	Local / General Anesthesia
Operations:			
Illnesses:			

V Social History

Approximately Daily Consumption of: Alcohol ____________ Tobacco ____________ Coffee ____________

VI Have you ever seen a Dermatologist? _____ Yes _____ No Dr. __________________ Date _____________

(If you would like us to request your records, please request a records release form.)

Form Completed By: ____ Date: ___________________