

Name \_\_\_\_\_ Date \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_\_\_

Reason for Visit? \_\_\_\_\_ Best phone # to reach you to discuss results? \_\_\_\_\_ Okay to leave a message? Y N

Preferred Pharmacy (Include Location) \_\_\_\_\_

Yes No Do you drink alcohol? If yes, how many drinks per day? \_\_\_\_\_ Occupation \_\_\_\_\_  
 Yes No Do you smoke? If yes, how many packs per day? \_\_\_\_\_  
 Yes No Do you use illegal street drugs? If yes, list \_\_\_\_\_

**PAST MEDICAL HISTORY**

Have you ever had any of the following?

Yes No Anxiety Yes No Hearing Loss  
 Yes No Artificial Joints Yes No Hepatitis  
 Yes No Asthma Yes No High Blood Pressure  
 Yes No Atrial Fibrillation Yes No HIV/AIDS  
 Yes No Cancer (non-skin) Yes No High Cholesterol  
 Yes No COPD Yes No Seasonal Allergies  
 Yes No Coronary Artery Disease Yes No Seizures  
 Yes No Depression Yes No Stroke  
 Yes No Diabetes Yes No Thyroid Disease  
 Yes No End Stage Renal Disease Yes No Valve Replacement  
 Other \_\_\_\_\_

**SKIN DISEASE HISTORY**

Please check all that apply

Yes No Actinic Keratosis  
 Yes No Basal Cell Skin Cancer  
 Yes No Melanoma (malignant)  
 Yes No Squamous Cell Skin Cancer  
 Yes No Precancerous Moles  
 Yes No (Atypical/Dysplastic)  
 Yes No History of bad or blistering sunburns?  
 Yes No Do you wear sunscreen?  
 If yes, what SPF? \_\_\_\_\_  
 Yes No Do you have family history of Melanoma?  
 If yes, who? \_\_\_\_\_

**REVIEW OF SYMPTOMS**

Are you currently experiencing any of the following?

Yes No Runny Nose/Itchy Eyes Yes No Enlarged Glands/Lymph Nodes  
 Yes No Palpitations/Chest Pain Yes No Joint Pains  
 Yes No Leg Swelling Yes No Muscle Aches  
 Yes No Fever/Chills Yes No Headaches  
 Yes No Unplanned Weight Loss Yes No Memory Loss  
 Yes No Cold/Heat Intolerance Yes No Depression  
 Yes No Excessive Thirst/Hunger Yes No Anxiety  
 Yes No Swallowing Problems Yes No Wheezing/Asthma  
 Yes No Mouth or Cold Sores Yes No Shortness of Breath  
 Yes No Nausea/Vomiting Yes No Suppressed Immune System  
 Yes No Diarrhea/Constipation Yes No Rash with Medication or Foods  
 Yes No Burning with Urination Yes No Problems Healing  
 Yes No Blood in Urine Yes No Scars/Keloids After Surgery  
 Yes No Do you have immediate family with a history of Skin Disease?  
 If yes, who/type? \_\_\_\_\_  
 Yes No Do you have immediate family with a history of Skin Cancer?  
 If yes, who/type? \_\_\_\_\_

**PAST SURGICAL HISTORY**

Please list previous surgical procedures

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
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 \_\_\_\_\_  
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**ALLERGIES**

Please list all allergies and reactions

\_\_\_\_\_  
 \_\_\_\_\_

**MEDICATIONS**

Please list all current medications (OTC, Herbal, Etc.)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ALERTS**

Are you currently experiencing any of the following?

Yes No Allergy to Latex or Tape Yes No Allergy to Lidocaine Yes No Allergy to Topical Antibiotic  
 Yes No Artificial Heart Valve Yes No Artificial Joint in Past 2 Months Yes No Accutane Used In Past 6 Months  
 Yes No Blood Thinner Use/Daily Aspirin Yes No Defibrillator Yes No Pacemaker  
 Yes No Medication Prior to Procedures Yes No Rapid Heart Rate w/ Epinephrine Yes No Pregnant/Breastfeeding  
 Yes No MRSA (Resistant Staph)

**EDUCATE YOURSELF**

Our physicians are experts in Cosmetic Dermatology procedures! Please help us maintain the highest level of customer service by checking all areas that interest you:

Botox Eyelid Rejuvenation Chemical Peels Facial Redness  
 Cosmetic Fillers Eyelash Rejuvenation Acne Scarring Sun Spots  
 Non-Surgical Nose Job Neck Rejuvenation Laser Hair Reduction Liposuction/Body Contouring  
 Lip Enhancement Neck/Chin Tightening Spider Vein Treatment Skin Care Advice  
 Underarm Odor/Sweating Sensitivity To Deodorant Double Chin Treatment

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_