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

_____
_____
_____
_____
_____

MEDICATIONS

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

_____
_____
_____
_____
_____

ALLERGIES

Please list all allergies and reactions

_____
_____

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:_____