New Patient Medical History

Patient's Name_____ Date of Birth _____ Age____ Today's Date _____

Reason for your visit **(Skin screenings & body checks are not covered by insurance)** _____

Allergies to medications □ penicillin □ sulfa □ neomycin □ adhesive □ other _____
Medications & dosages (include birth control, vitamins, supplements, homeopathic treatments) _____
_____
_____

Current skin care regimen (cleanser, soap, sunscreen, moisturizers, make up, topical medications)
_____
_____

Family History: Mother: □ living □ deceased age_____ Father: □ living □ deceased age_____
Sisters: living #____ deceased #_____ Brothers: living # ____ deceased #_____

Circle and check appropriate boxes for **current and/or past medical problems**:

Disease or Symptom	Patient	Mother	Father	Blood Relative
Skin Cancer-BCC, SCC, Melanoma/Precancers	☐	☐	☐	☐ who_____
Acne/Accutane/Eczema/Psoriasis/Photosensitivity/Vitiligo	☐	☐	☐	☐ who_____
Radiation treatment for acne, cancer	☐	☐	☐	☐ who_____
Ultraviolet light treatment for acne, psoriasis, CTCL	☐	☐	☐	☐ who_____
Indoor tanning bed 5, 10, 20, 50, 100, 500X	☐	☐	☐	☐ who_____
Hair loss, Increased hair	☐	☐	☐	☐ who_____
Infertility, Miscarriage, Irregular menses/PCOS/adrenal/	☐	☐	☐	☐ who_____
Breast cancer/Ovary cancer/Testicular Cancer	☐	☐	☐	☐ who_____
Allergies/Runny nose/Watery Eyes	☐	☐	☐	☐ who_____
Blood clots/Bleeding Disorder/ Leukemia/Lymphoma	☐	☐	☐	☐ who_____
Blood thinners/Coumadin/ASA/Plavix	☐	☐	☐	☐ who_____
Eye redness/Glaucoma/Cataract, _____	☐	☐	☐	☐ who_____
Arthritis /Joint pain/Psoriatic arthritis/ Lupus/Sjogrens/Raynauds dis/Rheumatoid arthritis/Scleroderma/Morphea/CREST	☐	☐	☐	☐ who_____
Ear/Nose/Throat/Mouth cancer/polyps _____	☐	☐	☐	☐ who_____
Headaches/Seizures/MS/Myasthenia Gravis/Muscle weakness/Polymylagia Rheumatica	☐	☐	☐	☐ who_____
Psychological dis/Depression/OCD/Picking	☐	☐	☐	☐ who_____
Thyroid /Pituitary/Diabetes/wt gain/ wt loss	☐	☐	☐	☐ who_____
Vasculitis/Wegener's/ITP, _____	☐	☐	☐	☐ who_____
Kidney/Bladder/Prostate/stones/cancer, _____	☐	☐	☐	☐ who_____
Pulmonary embolism/Lung cancer/asthma/bronchitis	☐	☐	☐	☐ who_____
Inflammatory bowel dis/UC/Crohns/diarrhea/GI cancer	☐	☐	☐	☐ who_____
High Blood Pressure/Heart disease/Stroke	☐	☐	☐	☐ who_____
Liver /Hepatitis/Gall Bladder/Pancreas/cancer _____	☐	☐	☐	☐ who_____

Females: Are you pregnant? □ yes □ no Nursing □ yes □ no planning to get pregnant? □ yes □ no Number of pregnancies __ children___ Last menstrual period_____ regular □ yes □ no every __d flow ___d Hysterectomy □ yes □ no when _____ Ovariectomy □ yes □ no when_____

Social History: Do you live alone? □ yes □ no Do you smoke? □ yes x __ yrs □ no Do you drink? □ yes __x/wk □ no Do you use recreational drugs? □ yes □ no Occupation: _____ If retired what was your work _____ Hobbies/outdoor activities _____
Severe sunburns □ yes □ no Indoor tanning □ yes □ no How many times? 5, 20, 50, 100, 500

Previous surgeries and/or hospitalizations include dates/years

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you interested in any of our cosmetic services or procedures? Please indicate below and our clinicians will be happy to discuss them with you.

Botox/Dysport for frown lines/crows feet correction _____

Fillers for wrinkles near mouth, jowls and under eyes _____

Collagen stimulators for volume restoration _____

Sclerotherapy/laser for unwanted spider/varicose veins _____

Dysport for sweating, TMJ-jaw clenching, migraines _____

Dysport/Botox for softening a square jaw line _____

Chemical peels for wrinkles and brown spots _____

IPL/Photofacial for redness/rosacea and brown spots _____

IPL w/ Levulan Kerastick for acne, severe photodamage and sun damage ___

Microdermabrasion for rough skin and acne _____

Treatment of brown discolorations (melasma) _____

Removal of unwanted hair _____

Softening, reduction of scars _____

Physician _____ Date _____
P.A. _____ Date _____
Nurse/MA _____ Date _____