

PATIENT MEDICAL HISTORY

(PLEASE ANSWER ALL QUESTIONS)

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Skin Cancer _____ Bleeding Disorders _____ Diabetes _____ Glaucoma _____ Hepatitis _____ Ulcers _____
High Blood Pressure _____ Tuberculosis _____ Heart Attack/Stroke _____ Heart Pacemaker _____ Venereal Diseases _____ AIDS/HIV _____
Asthma _____ Psoriasis _____ Malignant Melanoma _____ Eczema _____ Other Skin Problems _____

Penicillin Allergy: _____ Allergies to other medications or anesthetics: _____

List ALL other known allergies: _____

Do you have an artificial heart valve? Yes _____ No _____

Have you had joint replacement surgery? Yes _____ No _____

Do you have a family history of skin cancer? Yes _____ No _____

If YES, please indicate type of cancer: _____

List ALL Medications you are currently taking *including* over the counter medications, skin medications, multi-vitamins, Birth control, blood thinners, and hormone therapy, aspirin, laxatives.

Past operations: _____

BRIEFLY DESCRIBE YOUR CURRENT SKIN PROBLEM _____

HOW LONG HAVE YOU HAD THIS PRESENT SKIN PROBLEM? _____

INDICATE ON THE DIAGRAM THE AFFECTED PART(S) OF YOUR BODY (SEE DIAGRAMS BELOW)

(FEMALE PATIENTS: Are you pregnant? Yes _____ No _____ Planning to get pregnant? Yes _____ No _____)

(Are you breast feeding? Yes _____ No _____ Have you taken birth control pills? Yes _____ No _____)

