PATIENT HISTORY

Patient Name: ____ Date: ______________________________

Date of Birth :_____________________ Would you like a Full Skin Examination today? Yes □ No □

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list allergy and reaction: ______________

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List all medications you are currently taking and the doses: ____

List all previous operations and their dates: ____

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Do you have now or have you ever had any of the following diseases or conditions:

	Yes	No		Yes	No		Yes	No
Bronchitis	□	□	Diabetes	□	□	Obesity	□	□
Emphysema	□	□	Thyroid	□	□	Eczema	□	□
Asthma/Hay fever	□	□	Kidney	□	□	Seizures	□	□
Chronic cough	□	□	Bladder	□	□	Skin Cancer	□	□
Morning cough	□	□	Stomach	□	□	Psoriasis	□	□
High Blood Pressure	□	□	Bowel	□	□	AIDS	□	□
Chest Pain	□	□	Hepatitis	□	□	HIV	□	□
Heart Attack	□	□	Glaucoma	□	□	Arthritis	□	□
Convulsions, epilepsy	□	□	Varicose Veins	□	□	Atypical Moles	□	□
Heart Murmur	□	□	Shingles	□	□	Irregular Heart Beat	□	□
Fainting	□	□	Bleeding Disorders	□	□	Pacemaker	□	□
Cold Sores	□	□	Phlebitis	□	□	Genital Herpes	□	□
Melanoma	□	□						

Please list family members that have had or currently have any of the above: ___________________________

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Are you currently pregnant? Yes □ No □ Breast Feeding Yes □ No □

Do you drink alcoholic beverages? Yes □ No □ If yes, how often? ______________________________

Do you smoke? Yes □ No □ Quit x ________ If yes, how much per day? _____________________

Daily exercise: Sedentary □ Walk □ Jog □ Active Sports □ Gym □ Moderate □

Where were you born and raised? ____________________ Do you currently use sunscreen? Yes □ No □

What is your occupation?________________________ What are your hobbies? ______________________

What brand and kind of cosmetics and/or skin care products do you currently use? ______________________

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