Scottsdale Institute for Cosmetic Dermatology

MEDICAL HISTORY

Name_____ Date of Birth_____ Age_____

Reason for your visit today:_____

Do you have now, or have you ever had diseases or conditions of: *(If yes, please check box)*

Lungs
☐ Bronchitis ☐ Emphysema ☐ Asthma ☐ Chronic Cough ☐ Morning Cough

Vascular
☐ High Blood Pressure ☐ Chest Pain ☐ Heart Attack ☐ Heart Murmur
☐ Irregular Heartbeat ☐ Pacemaker ☐ Blood Clots/Phlebitis ☐ Mitral Valve Prolapse

Other Systemic
☐ Diabetes ☐ Thyroid ☐ Kidney ☐ Bladder ☐ Stomach
☐ Bowel ☐ Hepatitis A/B/C ☐ Glaucoma ☐ Arthritis/Joint

Current Medication	**Y**	**N**	If yes, please list:	Reaction?:
Do you have any allergies to food or medicine?	☐	☐		
Do you currently use any prophylactic antibiotics?	☐	☐	Which one?	
Are you currently taking any medications?	☐	☐	Please list:	
Are you taking any vitamins or herbal supplements?	☐	☐	Please list:	
Are you taking any over the counter medications?	☐	☐	Please list:	
Do you drink alcohol?	☐	☐	How much?	How often?
Do you currently use IV drugs?	☐	☐		
Have you ever been exposed to HIV/AIDS?	☐	☐		
Do you have an allergy to latex?	☐	☐		
Have you ever had a blood transfusion?	☐	☐		

Skin	**Y**	**N**	If yes,
Have you ever had skin cancer?	☐	☐	locations:_____
Family history of skin cancer?	☐	☐	relationship:_____
Do you currently use skin care products?	☐	☐	what kind:_____
Do cuts on your skin heal with normal scars?	☐	☐	

When exposed to sun, do you: Tan Tan & Burn Burn

When was your last total body skin exam? ☐ Less than 1 year ☐ More than 1 year ☐ Never

List any other disease or condition we should be aware of:_____

List surgical procedures (including cosmetic procedures):_____

Please answer the following questions	**Y**	**N**
Do you smoke?	☐	☐
Do you bleed easily?	☐	☐
Do you have artificial joints, pins or screws?	☐	☐
Do you require antibiotics prior to surgery?	☐	☐

	Y	**N**
Women: Are you pregnant?	☐	☐
Date of last menstrual period_____		
Have you had a hysterectomy?	☐	☐
Have you experienced menopause?	☐	☐

Immunizations: (Please list year if known) Tetanus_____ Shingles_____ Wart (Gardasil)_____ Date of last TB test (year)_____

Cosmetic

Do you have any interest in cosmetic procedures or have you had any of the following procedures performed?:

___Botox ___Fillers ___Wrinkle Therapy ___Mole Removal ___Blood Vessel/Spider Vein Destruction ___Skin Tag Removal

_____ _____

Patient's Signature Date

_____ _____

Physician / Physician's Assistant Signature Date