

# Medical History

Patient: \_\_\_\_\_ Date \_\_\_\_\_

Allergic to any medications? Reactions to anesthesia?  No  Yes If yes, please list:

1. \_\_\_\_\_ 2. \_\_\_\_\_

List all medications you are taking:

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

Do you have now (or ever had) one of the following conditions: (Please select Y/N)

Lungs	Yes	No	Other systemic:	Yes	No
Bronchitis	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>
Emphysema	<input type="radio"/>	<input type="radio"/>	Thyroid	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	Kidney	<input type="radio"/>	<input type="radio"/>
Vascular			Cancer	<input type="radio"/>	<input type="radio"/>
Hypertension	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>
Blood Clots	<input type="radio"/>	<input type="radio"/>	HIV	<input type="radio"/>	<input type="radio"/>
Bleed Easily	<input type="radio"/>	<input type="radio"/>			
Skin Diseases			Skin Cancer		
Lupus	<input type="radio"/>	<input type="radio"/>	Melanoma	<input type="radio"/>	<input type="radio"/>
Psoriasis	<input type="radio"/>	<input type="radio"/>	Squamous	<input type="radio"/>	<input type="radio"/>
Eczema	<input type="radio"/>	<input type="radio"/>	Basal	<input type="radio"/>	<input type="radio"/>

Please explain any yes answers above, or list other conditions not noted:

\_\_\_\_\_  
\_\_\_\_\_

Family History of skin diseases or cancers?  No  Yes If yes, please list:

1. \_\_\_\_\_ 2. \_\_\_\_\_

When exposed to sun, do you:  Tan only  Tan and Burn  Burn only

Frequency of tanning bed or outside tanning: \_\_\_ times a  week  month  year

Do you smoke?  No  Yes If yes, how much? \_\_\_\_\_ packs a day

Do you drink alcohol?  No  Yes If yes, how much? \_\_\_\_\_ drinks a day / week

I will notify the staff of any changes to this form when they occur:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_