What is the reason for your visit today?

Body Scan	Eczema	Acne	Cosmetic Questions
New Growth	Rash	Rosacea	Laser
Mole Growth	Psoriasis	Hives	Hair Loss
Face Exam	Itch	Warts	Nail Disease
Infection	Dermatitis	Cyst	Excessive Sweating

Other (Please Specify)

_____

Medical History:

What vitamins, prescription and over the counter medications are you currently taking?

Have you ever been treated by another dermatologist?
Yes No

If yes when and why_____

When was your last Full Body Check**?**_____

Do you have any medical problems? (Please check all that apply)

Pace Maker/Defibrillator	Neurological Disorders	Eczema	Melanoma
Heart Disease	Mental Illness	Psoriasis	Skin Cancer
High Blood Pressure	Kidney Problems	Hives	Shingles
Diabetes	Hepatitis	Allergies	Lupus
Excessive Bleeding	Thyroid Disease	Asthma	HIV/AIDS
Anemia	Reflux Disease	Acne	Hepatitis
Organ Transplant	Osteoporosis	Rosacea	Tuberculosis
			Problem with Scarring
			Problem with Keloids

Cancer (Specify Type)_____

Other _____

Allergic reaction to Latex? Yes No Allergic reactions to local anesthetics? Yes No

Are you allergic to any medications? (Please list)

Please list any and all surgeries you have had in the past (cosmetic and medical) with dates

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Patient's Name (Print): _____

Family History:

Any family history of: (Please include your relationship)

			Specify Family Member:
Skin Cancer?	Yes	No	_____
Melanoma?	Yes	No	_____
Acne?	Yes	No	_____
Eczema?	Yes	No	_____
Psoriasis?	Yes	No	_____
Diabetes?	Yes	No	_____
Cancer?	Yes	No	_____
Heart Disease?	Yes	No	_____

Other _____

Are you Pregnant? Yes No Are you planning a pregnancy? Yes No

(Please inform the doctor if you plan on becoming pregnant during your treatment period.)

Social History:

Do you use sunscreen?	Always	Sometimes	Never
Do you visit a tanning salon?	Always	Sometimes	Never

Have you ever had blistering sunburn? Yes No

What is your occupation?
_____

Do you smoke?
Yes No If yes, how many packs/day? _____ If you *were* a smoker, when stopped: ___/____

Do you consume alcohol?
Yes Socially or Regularly No Never

Areas of Aesthetic Concern: (Please circle all that apply)

Fine Lines & Wrinkles	Tired Looking or Uneven Skin Tone
Lines around the Lips & Mouth	Brown Spots/Freckles
Rough Texture of skin	Unwanted Hair
Dark Circles/Puffiness	Unwanted Skin Veins
Acne Scars	Skin Hyper pigmentation
Blood Vessels around Nose or Face	Eyelashes: Fuller, darker, longer
	Other: _____

Patient's Name (Print): _____