

Medical History

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Current Medications: (Including Topical Medications like Allergies and Reaction: (Including Latex, Medications,

Rein-A, Tretinoin, etc) food, if none, write “none” )

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Are you pregnant? Y N Are you nursing? Y N Are you planning on becoming pregnant? Y N

Are you currently taking ACCUTANE, or have you taken ACCUTANE in the last 6 months? Y N

Do you use tanning beds? Y N Do you wear sunscreen daily? Y N

Any dental work/cleaning in the last 2 weeks, or an upcoming appointment in the next 2 weeks? Y N

Personal Medical History: (Please check all that apply)

\_\_\_ Anemia \_\_\_ Copper IUD \_\_\_Keloid Scars

\_\_\_Autoimmune Disease \_\_\_Diabetes \_\_\_ Lupus

\_\_\_Bleeding Disorder \_\_\_Fibromyalgia \_\_\_ Metal Implants

\_\_\_ Blood Clots \_\_\_ Heart Disease \_\_\_ Pacemaker

\_\_\_ Cancer \_\_\_ Hepatitis B or C \_\_\_ Raynaud’s Disease

\_\_\_ Cochlear Implant \_\_\_ Herpes Simplex \_\_\_ Seizures

\_\_\_ Colitis \_\_\_ High Blood Pressure \_\_\_ Stroke

\_\_\_ Cold Sores \_\_\_ HIV / AIDS \_\_\_ Thyroid Disorder

\_\_\_ Connective Tissue Disorder \_\_\_ Hysterectomy \_\_\_ Valley Fever

\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Skin History: (Please check all that apply)

\_\_\_Undiagnosed Skin Lesions \_\_\_ Psoriasis \_\_\_ Actinic Keratosis

\_\_\_ Melasma/ “Pregnancy Mask” \_\_\_ Shingles \_\_\_ Eczema

\_\_\_ Pigment Disorder (ie Vitiligo)

\_\_\_ Skin Cancer (Melanoma, Basal Cell Carcinoma, Squamos Cell Carcinoma)

Previous Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature Date