



Name: _____ DOB: / / Date: / /

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 this in the last 6 months? Y__ N__

Past Personal Medical History: (please circle all that apply)

- | | | | |
|--------------------|----------------------------|---------------------|-------------------|
| Anemia | Chronic Cough | Heart Murmur | Phlebitis |
| Arthritis | Cold Sores | Irregular Heartbeat | Seizure Disorder |
| Artificial Joint | Colitis | Pacemaker | Stroke |
| Autoimmune Disease | Connective Tissue Disorder | Defibrillator | Thyroid Disorder |
| Bleeding Disorder | Diabetes | Herpes Simplex | Tuberculosis |
| Blood Clots | Dialysis | Hepatitis B or C | Ulcers |
| Breast Cancer | Depression | High Blood Pressure | Valley Fever |
| Bronchitis | Fibromyalgia | HIV/AIDS | Metal Implants |
| Burns | Heart Disease | Migraines | Raynaud's Disease |
| Cancer | Heart Valve | Multiple Sclerosis | |

Past Personal Skin History: (please circle all that apply)

- | | | | | |
|--------------------------|----------------------------|-----------|------------------|--------------|
| Undiagnosed Skin Lesions | Connective Tissue Disorder | Melanoma | Shingles | Keloid Scars |
| Actinic Keratosis | Serious Skin Infection | Psoriasis | Eczema | |
| Basal Cell Skin Cancer | Squamous Cell Skin Cancer | Lupus | Pigment Disorder | |

Have you ever seen a dermatologist or plastic surgeon for your skin? Y__ N__

If yes, explain: _____

Family History: (please circle all that apply)

- | | | | | |
|---------|----------|---------------|----------------------|--------------|
| Adopted | Diabetes | Heart Disease | Autoimmune Disorders | Skin Disease |
| Cancer | Melanoma | Stroke | High Blood Pressure | |

Review of Systems: (please circle) Do you currently have any of the following symptoms:

- | | | | | |
|----------------------|------------|-------------------|----------|-----------------------|
| Poor General Health | Headache | Suspicious Moles | Flushing | Bleeding Tendencies |
| Swollen Lymph Nodes | Chest Pain | Swollen Legs/Feet | Itching | Heat/Cold Intolerance |
| Circulation Problems | Numbness | Easy Bruising | Swelling | Non-healing Sores |
| Rashes | Fainting | | | |

Prescription/OTC Medications

Medication Allergy and Reaction

 Latex allergy? Y__ N__ Iodine allergy? Y__ N__

Topical Medications

- Retin A Refissa Tazorac
 Renova Differen
 Other: _____

Previous Surgeries?

Reviewed By: _____