



**PATIENT REGISTRATION & HEALTH QUESTIONNAIRE CONTINUED...**

**MEDICAL HISTORY**

Do you have any history of:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Artificial Joints  | <input type="checkbox"/> <input type="checkbox"/> Family of Bleeding Problems | <input type="checkbox"/> <input type="checkbox"/> Heart Disease           |
| <input type="checkbox"/> <input type="checkbox"/> Liver Disease/Hepatitis  | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur                | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever         |
| <input type="checkbox"/> <input type="checkbox"/> Bleeding Problems  | <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve      | <input type="checkbox"/> <input type="checkbox"/> Keloids                 |
| <input type="checkbox"/> <input type="checkbox"/> Difficulty Healing Wounds  | <input type="checkbox"/> <input type="checkbox"/> Pacemaker: _____            | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease          |
| <input type="checkbox"/> <input type="checkbox"/> Emotional Disorders  | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> <input type="checkbox"/> Blood Clots             |
| <input type="checkbox"/> <input type="checkbox"/> Fever Blisters   | <input type="checkbox"/> <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> <input type="checkbox"/> Glaucoma                |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems   | <input type="checkbox"/> <input type="checkbox"/> Hernias                     | <input type="checkbox"/> <input type="checkbox"/> Taken Medicine Accutane |
| <input type="checkbox"/> <input type="checkbox"/> Immune Deficiency/HIV  |   |   |
| <input type="checkbox"/> <input type="checkbox"/> Require Antibiotics before medical/dental Procedures? If yes, why? _____ |   |   |
| <input type="checkbox"/> <input type="checkbox"/> Any complications with previous surgeries? _____                         |   |   |
| <input type="checkbox"/> <input type="checkbox"/> Prior Cosmetic Procedures: _____   |   |   |

Additional info for "yes" answers:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CURRENT MEDICATION/DRUG ALLERIGES: include dietary supplements, aspirin, and birth control pills**

Current Medication/Dosage  
(or provide list)

Drug Allergies

- |          |          |
|----------|----------|
| 1. _____ | 1. _____ |
| 2. _____ | 2. _____ |
| 3. _____ | 3. _____ |
| 4. _____ | 4. _____ |
| 5. _____ | 5. _____ |
| 6. _____ | 6. _____ |

**DERMATOLOGIC HISTORY**

- Is there a history of melanoma in your immediate family? Yes  No If yes, who? \_\_\_\_\_
- Do you have a history of excessive sun exposure or sunburn? Yes  No
- Do you regularly sunbathe or visit tanning salons? Yes  No
- Do you regularly apply sunblock to exposed areas Yes  No Which SPF? \_\_\_\_\_
- Do you or does anyone in your family have a history of any skin disease? (rashes, eczema, psoriasis, etc.) Yes  No If yes, explain below \_\_\_\_\_  
\_\_\_\_\_
- What is the primary reason for your visit today? (Check all that apply) Acne Rash Hair loss Cosmetic (Hair Transplant/Collagen/Botox/Laser Procedures, etc.) Changing Mole/Skin Growth Full Body Check/Skin Cancer Screening Other \_\_\_\_\_

*PLEASE NOTE THAT MULTIPLE PROBLEMS MAY REQUIRE MORE THAN ONE VISIT*

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date