

PERSONAL MEDICAL HISTORY

Name _____ Date _____

Age _____ Date of Birth _____ SS# _____ - _____ - _____

Address _____ City/State _____ Zip _____

Home Phone _____ Alternate Phone _____

How did you hear about us? _____

What type of condition are you consulting for today? (check all that apply)

- Sun spots or freckles
- Wrinkles
- Distended blood vessels (red spots that may be spidery in appearance)
- Flushing of the skin, rosacea or poikiloderma
- Large pores
- Hemangioma or cherry angioma

When did your first notice this condition(s)?

At what age did this skin condition(s) occur?

Is your present skin condition(s) getting more pronounced? Yes No

Have you received prior treatment for this condition(s) Yes No

If yes, when? _____

By what method? _____

Are you currently taking any medication for your skin condition? Yes No

If yes, what medication(s)?

Are you pregnant, nursing or planning a pregnancy soon? Yes No

Do you have a history of keloid scarring? Yes No

PERSONAL MEDICAL HISTORY CONT.

Do you have a history of:

- | | | |
|---|--|---|
| <input type="checkbox"/> Septicemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Herpes Sores |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Dark spots after pregnancy |
| <input type="checkbox"/> Skin Injury | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anaphylaxis |
| <input type="checkbox"/> Multiple Severe Allergies | <input type="checkbox"/> Facial Acne | <input type="checkbox"/> Facial Rashes |
| <input type="checkbox"/> Facial Hives | <input type="checkbox"/> Facial Herpes | |
| <input type="checkbox"/> Active Inflammatory Process or Infection (at proposed injection sites) | | |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Immunosuppressive Therapy | |
| <input type="checkbox"/> Other _____ | | |

Are you allergic to anesthesia, including lidocaine? Yes No

Do you have any allergies, especially skin related? Yes No

If yes, please specify _____

Are you allergic to any medications? Yes No

If yes, please specify _____

Are you taking any medications/supplements?

- | | | |
|---|---|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Anti-coagulants | <input type="checkbox"/> Hormones/contraceptives |
| <input type="checkbox"/> Cortisone/Steroids | <input type="checkbox"/> Thyroid medication | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Sedatives | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Appetite suppressant |
| <input type="checkbox"/> Anti-inflammatories/NSAIDS | | <input type="checkbox"/> Ginko Biloba |
| <input type="checkbox"/> Vitamin A | <input type="checkbox"/> Vitamin E | <input type="checkbox"/> Flax Oil |
| <input type="checkbox"/> Other (please specify) _____ | | |

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient Name (*print*): _____

Signature: _____

Witness: _____

Date: _____

Steven Tidwell, M.D./Heidi Garguilo, ARNP-BC