OB-GYN Associates, P.C.

Cosmetic Solutions
Laser & Skin Care Center

## PATIENT MEDICAL AND HEALTH HISTORY

**Today's Date: _____**

**Name: _____ D.O.B.: _____ Age: _____**

**What is the reason for your visit?**

_____

_____

Have you ever been or are you currently under the care of a dermatologist or plastic surgeon? YES NO

If Yes, when and for what condition/treatment? _____

**Health History:**

Do you have or have you ever had: (If yes, please give date/further information)

| | | | |
|---|---|---|---|
| Cancer/Skin Cancer | YES NO _____ | Regular Sun/Tanning Bed Exposure | YES NO _____ |
| Diabetes | YES NO _____ | Photosensitive to Sunlight | YES NO _____ |
| Jaundice | YES NO _____ | Waxing/ Tweezing | YES NO _____ |
| Anemia | YES NO _____ | Electrolysis | YES NO _____ |
| Varicose Veins | YES NO _____ | Microdermabrasion | YES NO _____ |
| Heart Disease/Murmur | YES NO _____ | Laser Treatment | YES NO _____ |
| Embolism/Blood Clot | YES NO _____ | Tattoo or permanent make-up | YES NO _____ |
| Asthma | YES NO _____ | Chemical Peel | YES NO _____ |
| Mental Illness | YES NO _____ | Sclerotherapy | YES NO _____ |
| Migraine Headaches | YES NO _____ | Botox/Dermal Fillers | YES NO _____ |
| High Blood Pressure | YES NO _____ | Vitiligo | YES NO _____ |
| Collagen Disease | | Herpes/Cold Sores/Sun Blisters | YES NO _____ |
| (Lupus, Scleroderma) | YES NO _____ | Keloid/Scarring | YES NO _____ |
| Chronic Skin Disorder | YES NO _____ | Use of Accutane for acne | YES NO _____ |
| Seizure Disorder | YES NO _____ | Liposuction | YES NO _____ |
| Neurological Disease | YES NO _____ | Pacemaker/Defibrillator/Implant | YES NO _____ |
| Immunological Disease | YES NO _____ | | |

Other _____

Surgeries you have had: _____

Do you smoke: YES NO Have you ever smoked: YES NO How much? _____ How long? _____

Are you pregnant or trying to get pregnant? YES NO

**Current Medications/ Supplements:** _____

_____

**Allergies to Medications:** YES NO If yes, to what? _____
**Environmental Allergies:** YES NO If yes, to what? _____
**Allergy to Latex:** YES NO