OB-GYN Associates, P.C.

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)

Condition			Condition		
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

Reviewed 6/3/2019