MIDAMERICA SKIN HEALTH & VITALITY CENTER

Joseph A. Muccini, MD **Rebecca J. Smith PA-C**

Medical History

Patient: _____ Age: _____ Date: _____ Sex: M / F

Referring Physician: _____ Family/Primary Care Physician: _____

My general health is: (circle one) Excellent Good Fair Poor

Do you now, or have ever suffered from, any of the following conditions (please check only the ones that apply)

SKIN
□ Melanoma
□ Basal Cell Carcinoma
□ Squamous Cell Carcinoma
□ Actinic Keratosis
□ Family history of skin cancer (which types?) _____
_____
□ Fungus infections
□ Accutane used in the past
□ Radiation therapy for acne
□ Rosacea
□ Psoriasis
□ Lupus
□ Eczema
□ Vitiligo
□ Ehlers-Danlos disease
□ Abnormal scarring
□ Hypertrophic scars
□ Painful scars
□ Keloids
□ Electrolysis (past or present)
□ Infections
□ Herpes simplex
□ Cold sores
□ Fever blisters
□ Warts
□ Hives
□ *NONE OF THE ABOVE*

LYMPHATIC
□ Lymphedema
□ Leg swelling
□ *NONE OF THE ABOVE*

CARDIOVASCULAR
□ High blood pressure
□ Low blood pressure
□ Pacemaker
□ Bleeding tendency
□ Bruising tendency
□ Hemorrhage tendency
□ Heart murmurs
□ Blood clots: legs, lungs
□ Thrombophlebitis
□ Pulmonary embolus
□ Venous stasis
□ Coronary artery disease
□ Chest pain
□ Bypass surgery
□ *NONE OF THE ABOVE*

SKELETAL/MUSCULAR
□ Osteoporosis
□ Double-jointedness
□ Bone or joint disease
□ Joint dislocations
□ Broken or brittle bones
□ Prosthetic devices implanted: (artificial hips, artificial joints, implants, prosthetic devices, etc.)
□ *NONE OF THE ABOVE*

OPTHALMIC
□ Glaucoma
□ Cataracts
□ *NONE OF THE ABOVE*

RESPIRATORY
□ Asthma
□ Shortness of breath
□ Chronic obstructive-pulmonary disease
□ Bronchitis
□ Emphysema
□ Wheezing
□ *NONE OF THE ABOVE*

ENDOCRINE
□ Hypo-thyroid
□ Hyper-thyroid
□ Diabetes
□ Use of any thyroid meds under the care of a physician
□ Duodenal ulcer
□ Organ transplants
□ *NONE OF THE ABOVE*

NUTRITION/ENDOCRINE
□ Diabetes
□ Excessive thirst/hunger
□ Amputations
□ High blood sugar
□ Low blood sugar
□ Vegetarian
□ Nutritional disorders: (which disorders?) _____
_____
_____
□ *NONE OF THE ABOVE*

NEUROLOGIC
□ Convulsions
□ Epilepsy/Seizures
□ Fainting
□ *NONE OF THE ABOVE*

URINARY
□ Kidney infections
□ Recurrent UTI's
□ Renal/kidney problems
□ Sugar in the urine
□ *NONE OF THE ABOVE*

GASTROINTESTINAL / LIVER
□ Intestinal ulcers
□ Gastric bypass surgery
□ Stomach disorders
□ Nausea/vomiting when taking antibiotics
□ Hepatitis A, B, C
□ History of Liver Disease
□ *NONE OF THE ABOVE*

IMMUNE
□ HIV/AIDS
□ Seasonal allergies
□ Hay fever
□ Allergy to cold
□ Cryoglobulinemia
□ Raynaud's disease
□ TB
□ Organ transplants
□ Immunosuppression
□ *NONE OF THE ABOVE*

CANCER
□ History of cancer (which types?) _____
_____

REPRODUCTIVE
□ Pregnant/Gestation period/Due Date: _____
□ Date of last menstrual period: _____

SOCIAL
□ Smoke (If yes, how much?): _____
□ Drink (If yes, how much/when?): _____
□ Depression
□ Have you ever sought the help of a psychiatrist, psychologist, or psychiatric social worker?

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE →

Medical History (Cont'd)

Pharmacy Name (Required): _____ Pharmacy Phone (Required): _____

Pharmacy City & Street (Optional): _____

Do you have any allergies or reactions of the following drugs:

LOCAL ANESTHETIC AGENTS
□ Xylocaine
□ Lidocaine
□ Carbocaine
□ Mepivacaine
□ Novocaine
□ Procaine
□ Pontocaine
□ Cetacaine
□ Tetracaine

ANTIBIOTICS
□ Sulfonamide
□ Penicillin
□ Erythromycin
□ Tetracycline
□ Gels or lotions
□ Antibiotic/cortisone cream
□ Ointment:_____
_____

PAIN MEDICATIONS
□ Demerol
□ Codeine
□ Any other medications: _____
Reaction(s) to these medications:_____
_____
_____
_____
_____

Please list any additional chronic illnesses: _____

Please list your history of any past or present cancer (not skin related): _____

Have you ever had surgery or been hospitalized for a condition not explained above?: _____

_____

Have you ever had any consultations or evaluations for cosmetic surgery?: _____

_____

Any medications you cannot take or are not supposed to take: _____

_____

Please List Your Current Medications (Request an additional page if needed or attach your copied list)

Drug Name	Dosage

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____

Guardian Signature: _____ Date: _____