MEDICAL INFORMATION

I. MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD:

	YES	NO
HEART ATTACK/ANGINA	__	__
HEART MURMUR	__	__
ARTIFICIAL HEART VALVE/JOINT	__	__
HIGH BLOOD PRESSURE	__	__
DIZZINESS/FAINTING TENDENCY	__	__
PACEMAKER	__	__
DEFRIBILLATOR	__	__
FREQUENT OR SEVERE HEADACHES	__	__
EPILEPSY/STROKE	__	__
BLEEDING PROBLEMS	__	__
ANEMIA OR BLOOD DISORDER	__	__
POOR WOUND HEALING	__	__
SKIN PIGMENT PROBLEMS	__	__
KELOIDS OR ABNORMAL SCARS	__	__
DIABETES	__	__
THYROID CONDITION	__	__
HEPATITIS/LIVER DISEASE	__	__
AIDS/HIV	__	__
FEVER BLISTERS/COLD SORES	__	__
TUBERCULOSIS	__	__
ASTHMA	__	__
DEPRESSION/MENTAL ILLNESS	__	__
ARE YOU PREGNANT/ NURSING?	__	__

II. MEDICATIONS

ARE YOU SENSITIVE OR ALLERGIC TO:

	YES	NO
PENICILLIN	__	__
LOCAL ANESTHETIC	__	__
GENERAL ANESTHETIC	__	__
ANY OTHER MEDICATIONS	__	__

IF SO WHAT? _____

_____

HAVE YOU EVER HAD (PLEASE CIRCLE):

BASAL CELL CARCINOMA/ SQUAMOUS CELL CARCINOMA/ MELANOMA

OTHER SKIN DISORDERS _____

_____

IF SO (YEAR/SURGERY TYPE/DR. WHO DID SURGERY):

_____

_____

_____

FAMILY HISTORY (PLEASE CIRCLE):

SKIN CANCER/MELANOMA

OTHER: _____

_____

IV. PAST MEDICAL HISTORY (TYPE OR NAME/YEAR OPERATIONS):

_____

_____

_____

SOCIAL HISTORY

APPROXIMATELY DAILY CONSUMPTION OF: ALCOHOL _____ TOBACCO_____CAFFEINE_____

RECREATIONAL DRUG USE: YES___ NO___

HAVE YOU EVER SEEN A DERMATOLOGIST? ___YES___NO **DR.**_____

IF YOU WOULD LIKE US TO REQUEST YOUR RECORDS, PLEASE REQUEST A RECORDS RELEASE FORM.

COMPLETED BY: DATE: