MRN# _____

NAME: _____TODAYS DATE: _____

HEIGHT: _____ WEIGHT: _____ PHARMACY: _____

PERSONAL PAST/PRESENT MEDICAL HISTORY

Have you received the Flu Vaccine this year? ◯ YES DATE _____ ◯ NO
Have you received the Pneumonia Vaccine? ◯ YES DATE _____ ◯ NO

◯ Seasonal Allergies ◯ Diabetes ◯ Asthma ◯ Anxiety

◯ Latex Allergy ◯ Depression ◯ Hepatitis C ◯ Lymphoma/Leukemia

◯ Seizures ◯ Stroke ◯ High Blood Pressure ◯ Atrial Fibrillation

◯ High Cholesterol ◯ Pacemaker/Defibrillator ◯ Thyroid (Hypo / Hyper) ◯ Emphysema/COPD

◯ Organ Transplant ◯ HIV/AIDS ◯ Kidney Disease

◯ Pregnant ◯ YES ◯ NO (if yes how far along) _____ ◯ Breast Feeding ◯ YES ◯ NO

◯ Coronary Artery Disease (Heart Attack) When _____ ◯ Joint Replacement - When _____

◯ Arthritis (Osteoporosis, Rheumatoid, Psoriatic) _____

◯ Cancer Type: _____ (When) _____

◯ Surgeries _____

◯ None of the above

GENERAL HEALTH INDICATORS

◯ Fevers ◯ Night Sweats ◯ Change in Appetite ◯ Bruising Easily

◯ Problems Healing ◯ Fatigue ◯ Hypertrophic or Keloid Scars (raised, lumpy scar)

◯ Poor Balance ◯ Recently Fallen - When _____

◯ Other unusual or abnormal conditions _____

Do you feel safe at home? ◯ Yes ◯ No Do you have and advanced directive? ◯ Yes ◯ No

PERSONAL SKIN DISEASE HISTORY

◯ Eczema ◯ Psoriasis ◯ Actinic Keratosis ◯ Oral Herpes (cold sores) ◯ Acne

◯ Basal Cell Carcinoma ◯ Squamous Cell Carcinoma ◯ Melanoma

FAMILY SKIN CANCER HISTORY

◯ Melanoma If yes, which relative(s) _____
◯ Basal Cell Carcinoma ◯ Squamous Cell Carcinoma If yes which relative(s) _____

SOCIAL HISTORY

Illicit Drug Use ◯ No ◯ Yes Type _____(How Often)_____

Alcohol Use ◯ No ◯ Yes (How Often) _____(How Much)_____

Cigarette Smoking ◯ No ◯ Quit (When) _____ ◯ Yes (How often) _____(How Many) _____

MEDICATIONS

Name _____Dose_____ Name _____Dose_____
Name _____Dose_____ Name _____Dose_____
Name _____Dose_____ Name _____Dose_____

Name _____Dose_____ Name _____Dose_____

MRN# _____

DRUG ALLERGIES (List drugs and reactions) ◯ No ◯ Yes (if yes please list)

Name _____ Reaction_____
Name _____ Reaction_____
Name _____ Reaction_____

Allergy to Lidocaine? ◯ YES ◯ NO
Allergy to epinephrine? ◯ YES ◯ NO
Allergy to adhesives or topical antibiotics? ◯ YES ◯ NO (If yes to what)_____

COSMETICS

Are you interested in a cosmetic procedure? ◯ YES ◯ NO

If yes, what type?

Botox ◯ YES ◯ NO
Fillers ◯ YES ◯ NO

Do you wish to talk with our aesthetician? ◯ YES ◯ NO

If yes, what are you interested in?

Facials ◯ YES ◯ NO
Products ◯ YES ◯ NO

Contact Phone Number: _____Home _____Cell
When is a good time to call? _____ Ok to leave a message? ◯ YES ◯ NO