

**Danvers Family Doctors, P.C.**  
**Medical History Form**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_ Phone: H \_\_\_\_\_ Cell \_\_\_\_\_

Address: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_ Email: \_\_\_\_\_

**Have you had in the past or do you currently have? :**

Pigmentation issues, hyper or hypo pigmentation	Y	N	Heart Disease	Y	N
Diabetes	Y	N	Irregular Pulse	Y	N
Gold Therapy	Y	N	Fainting Spells	Y	N
Seizure Disorder ( Epilepsy )	Y	N	Asthma	Y	N
High Blood Pressure	Y	N	Keloid Formation	Y	N
Polycystic Ovarian Syndrome	Y	N	Rosacea	Y	N
Irregular Menses	Y	N	Lupus	Y	N
Thyroid Disorder	Y	N	Hepatitis	Y	N
History of Herpes Simplex infections/fever blisters	Y	N	Chemotherapy	Y	N
Acne	Y	N	Skin Cancer	Y	N
Are you Photosensitive	Y	N	Have you ever used <b>Retin-A</b> ?	Y	N
Have you ever had a chemical peel or microderm?	Y	N	Have you ever taken <b>Acutane</b> ?	Y	N
Do you have any Tattoos or permanent makeup?	Y	N	Cancer	Y	N
Have you ever had any laser treatments?	Y	N	Other medical issues or illnesses	Y	N
			Radiation therapy.	Y	N

**Medications:** (Please list any medications you are currently taking including herbal supplements and vitamins.)

What topical medications or creams are you currently using? Retin-A, Others?

Are you taking mood altering or anti-depression medication? \_\_\_ Y \_\_\_ N

Are you under the care of a physician? \_\_\_ Y \_\_\_ N If yes, why? \_\_\_\_\_

**Drug Allergies:** (Please list any known drug allergies) : \_\_\_\_\_

Have you had any recent tanning, sun exposure or used tanning creams that changed the color of you skin? Y N

Do you use sunscreen? \_\_\_ Y \_\_\_ N What SPF? \_\_\_\_\_ Do you scar easily? \_\_\_ Y \_\_\_ N Do you heal quickly? \_\_\_ Y \_\_\_ N

Have you used any of the following hair removal methods in the past six weeks?

Shaving \_\_\_ Waxing \_\_\_ Electrolysis \_\_\_ Tweezing \_\_\_ Threading \_\_\_ Depilatories \_\_\_

**Please mark area(s) of interest:**

Hair Removal \_\_\_\_\_ Brown Spots \_\_\_\_\_ Wrinkles \_\_\_\_\_ Rosacea \_\_\_\_\_ Facial Veins \_\_\_\_\_ Sagging Skin \_\_\_\_\_

What treatments would you like to discuss today? \_\_\_\_\_

**For our female patients:** Are you pregnant or trying to become pregnant? \_\_\_ Yes \_\_\_ No

*I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the staff at Danvers Family Doctors, P.C. of my current medical or health conditions and to update this history with any changes that my occur. A current medical history is essential for the caregiver to execute appropriate treatment procedures*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_