MEDICAL HISTORY FORM

Patient:_____ Today's Date:___/___/____

DOB:_____ Male_____ Female _____ Other_____

ALLERGIES:_____

List all MEDICATIONS you are currently taking (including prescriptions or over the counter)

_____

_____

Pharmacy address and phone:_____

MEDICAL HISTORY:
Do you have now, or have you had diseases or conditions of:

___Anxiety
___Arthritis
___Asthma
___Atrial Fibrillation
___Blood thinner
___Bone Marrow Transplant
___Benign Prostate Hypertrophy
___Breast Cancer
___Colon Cancer
___COPD
___Coronary Artery Disease
___Depression
___Diabetes
___End Stage Renal Disease
___GERD
___Hearing Loss
___Artificial Heart Valve
___ Hepatitis
___ HSV
___ High Blood Pressure
___ HIV/ AIDS
___ High Cholesterol
___ Hyperthyroidism
___ Hypothyroidism
___ Leukemia
___ Lung Cancer
___ Lymphoma
___ Prostate Cancer
___ Radiation Treatment
___ Seizures

List any other diseases or conditions:_____
Surgical Procedures:_____

EMBRACE DERMATOLOGY AND AESTHETICS, LLC
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SKIN HISTORY:

___ Acne
___ Actinic Keratosis
___ Basal Cell Carcinoma
___ Blistering Sunburn
___ Dry Skin
___ Eczema
___ Flaking or Itchy Scalp
___ Hay Fever/Allergies
___ Melanoma
___ Poison Ivy
___ Precancerous Moles
___ Psoriasis
___Squamous Cell Carcinoma

Other: _____

Has anyone in your family had melanoma? ____ YES ____ NO
Do you have a family history of skin cancer? ____ YES ____ NO

SOCIAL HISTORY:

Tobacco Use:___ Never Smoked ____Former Smoker ____ Current Smoker
Do you drink alcohol? ___ YES ___ NO . If YES, ____ drinks/ day

Have you received your pneumonia vaccine? ___ YES ___ NO
Have you received your flu vaccination this year? ___YES ___ NO

COSMETIC SERVICES:

I am interested in discussing?

___ Botox ___ Fillers ___ Chemical Peels ___Microneedling ___Medical Grade Skincare

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