

MEDICAL INFORMATION FOR TODAY'S VISIT

NAME: _____ AGE _____ SEX: M / F TODAY'S DATE: ___ / ___ / ___

REASON FOR YOUR VISIT? _____

WHO WERE YOU REFERRED BY? _____

OCCUPATION: _____

CURRENT MEDICATIONS:

CURRENT ALLERGIES:

To medication:

To foods:

To chemicals/metals:

DO YOU OCCASIONALLY USE:

Motrin/Other NSAIDS _____
Aspirin/Blood Thinners _____
Birth Control _____
Itching Pills _____
Allergy Pills _____

SOCIAL HISTORY:

Pregnant/Nursing? Yes/No
Do you smoke cigarettes? Yes/No
Do you use alcohol? Yes/No

CURRENT MAJOR MEDICAL PROBLEMS:

DO YOU HAVE ANY OF THESE CONDITIONS:

Reactions to anesthesia? _____ lidocaine? _____
Asthma or lung disease? _____
Diabetes? _____
High blood pressure? _____
Depression/Anxiety? _____
Thyroid disease? _____
Bleeding tendencies? _____
AIDS/HIV? _____
Pacemaker? _____
Artificial heart valve or joint _____
Hepatitis? _____

HAVE YOU EVER HAD A MOLE REMOVED? _____ IF YES, WAS IT NORMAL? _____

HAVE YOU EVER HAD SKIN CANCER? _____ IF YES, Basal cell carcinoma
Squamous cell carcinoma

HAVE YOU EVER HAD MELANOMA? _____ IF YES, WHEN&WHERE WAS IT DIAGNOSED?

HAS ANY FAMILY MEMBER HAD AN ABNORMAL MOLE OR MELANOMA? (Circle One)
WHO? _____

ANY FAMILY HISTORY OF A SKIN CONDITION? (Psoriasis, Eczema, Other)?

