# CONFIDENTIAL MEDICAL HISTORY

Name: _____ Age: _____ Date:_____

Please list all present prescription and non-prescription medications:

_____

_____

Are you allergic to any medications, latex, skin adhesives, food products, or any other substances? *YES / NO*
Which?_____
What are your symptoms?_____

Reason(s) for your visit: _____

## PATIENT MEDICAL HISTORY
(PLEASE MARK EACH INQUIRY)

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Eczema | | | Hives | | | Easy Bruising or Bleeding | | |
| Skin Disease | | | Kidney Stones | | | Ear Problems | | |
| Breast Cancer | | | Stroke | | | Autoimmune Disorder | | |
| Skin Cancer | | | Thyroid Disorder | | | Anemia | | |
| Other Cancer | | | Tuberculosis | | | Fibromyalgia | | |
| Asthma, other than as a child | | | Ulcers | | | Gallstones | | |
| Diabetes | | | Xray Therapy | | | Back injury/Pain | | |
| Chest Pain/Tightness | | | Urinary Tract Infection | | | Deep Vein Thrombosis or P.E. | | |
| Heart Disease | | | Dry Eyes | | | Chron's Disease or Ulcerative Colitis | | |
| Heart Murmur | | | Watery Eyes | | | | | |
| Hepatitis | | | Blurry Vision | | | | | |
| High Blood Pressure | | | Reflux/Heartburn | | | | | |

Explanation of above "yes" answers:

_____

_____

Please list all surgical procedures and hospitalizations, with approximate date (please include cosmetic surgery procedures):

_____

_____

## PATIENT FAMILY HISTORY
(PLEASE MARK EACH INQUIRY)

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Abnormal bleeding | | | Endocrine Disease | | | Malignant Hyperthermia | | |
| Abnormal Clotting | | | Epilepsy | | | Other Cancer | | |
| Anesthesia Problems | | | Glaucoma | | | Ovarian Cancer | | |
| Autoimmune Disorders | | | Hearing Loss | | | Prostate Cancer | | |
| Brain Tumor | | | Heart Disease | | | Skin Cancer | | |
| Breast Cancer | | | Hemophilia | | | Skin Disease | | |
| Cleft Lip | | | High Blood Pressure | | | Substance Abuse | | |
| Cleft Palate | | | Kidney Disease | | | Von Willebrand | | |
| Diabetes | | | Liver Disease | | | | | |
| Drug Allergies | | | Lung Cancer | | | | | |

Explanation of above "yes" answers:

_____

_____

(OVER)

(CONTINUED...)

Do you consume beer, wine or other alcoholic beverages? *YES / NO* If so, how often? Do you have a histoy of alcoholism? *YES / NO*

_____

Do you smoke or use any form of tobacco or nicotine? *YES / NO* If so, how much, and for how long? Have you quit smoking? *YES / NO*

_____

Any use of "recreational" drugs such as marijuana, "ice," ecstasy, cocaine, or other stimulants? *YES / NO* If so, which and how often?

_____

_____

Do you exercise regularly? *YES / NO* If yes, how often and what type(s) of exercise?_____

## PATIENT ABILITY TO HEAL

| | YES | NO |
|---|---|---|
| Does your skin appear fragile, burns easily? | | |
| Do you form thick or raised scarring from cuts or burns? | | |
| Do you use wax or depilatories on your face? | | |
| Do you ever get cold sores? | | |

## FEMALE QUESTIONS

| | YES | NO | N/A |
|---|---|---|---|
| Do you have regular periods? | | | |
| Are you going through or past menopause? | | | |
| Are you pregnant or lactating? | | | |
| During pregnancy, did you ever get hyperpigmentation or masking? | | | |

How many pregnancies? _____ Births?_____ Years for births _____

## HEIGHT/WEIGHT

| | |
|---|---|
| Height (ft) | |
| Height (in) | |
| Weight (lbs) | |

_____

PATIENT SIGNATURE

NOTES: