PATIENT MEDICAL HISTORY

(PLEASE ANSWER ALL QUESTIONS)

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Skin Cancer _____ Bleeding Disorders ____ Diabetes ____ Glaucoma ____ Hepatitis ____ Ulcers____

High Blood Pressure ____Tuberculosis ____ Heart Attack/Stroke ____ Heart Pacemaker ____ Venereal Diseases ____ AIDS/HIV ____

Asthma ____ Psoriasis ____ Malignant Melanoma ____ Eczema ____ Other Skin Problems _____

_____

Penicillin Allergy: Y____N_____

List ALL other known allergies: _____

Do you have an artificial heart valve? Yes ____ No ____

Have you had joint replacement surgery? Yes ____ No ____

Do you have a family history of skin cancer? Yes ____ No ____

If YES, please indicate type of cancer: _____

List ALL Medications you are currently taking *including* over the counter medications, skin medications, multi-vitamins, Birth control, blood thinners, and hormone therapy, aspirin, laxatives.

_____

_____

Past operations: _____

_____

BRIEFLY DESCRIBE YOUR CURRENT SKIN PROBLEM_____

HOW LONG HAVE YOU HAD THIS PRESENT SKIN PROBLEM? _____

INDICATE ON THE DIAGRAM THE AFFECTED PART(S) OF YOUR BODY (SEE DIAGRAMS BELOW)

(*FEMALE PATIENTS:* Are you pregnant? Yes ____ No ____ Planning to get pregnant? Yes ____No___)

(Are you breast feeding? Yes ____ No ____ Have you taken birth control pills? Yes ____ No ____)