

MEDICAL HISTORY FORM

Name: _____

Date: _____

Do you have or have had any of the following:			Do you or any of your "blood" relatives have or have had any of the following:			
	YES	NO		YES	NO	Relative
High blood pressure			Diabetes			
Ulcer			Lupus-skin or systemic			
Heart failure			Skin cancer or Melanoma			
Irregular heart beat			Asthma			
Cardiac pacemaker			Hay Fever			
Epilepsy			Eczema			
Glaucoma			Psoriasis			

If you have AIDS, infected with the HIV virus or concerned that you may be at risk, please discuss this with the doctor. *(This information will be kept confidential!)*

What is your skin problem? (rashes, growths, warts, etc.....) _____

When did you first notice the problem? _____

Where on your body is the problem located? _____

Have you had any other skin problems? Please list: _____

Women:

Are you pregnant? _____ Are you planning to become pregnant? _____

Are you taking hormone or Birth Control Pills? _____

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MEDICAL HISTORY FORM CONT'D

Please check YES or NO and answer the following:

Are you allergic to any medications? (penicillin, aspirin, sulfa, etc...) Please list:

Yes	No

Does anything that touches your skin cause rashes? (jewelry, poison oak, etc.)

Yes	No

Please list: _____

Are you being treated by a doctor? If yes, for what?

Yes	No

Are you taking any aspirin or blood thinners? Please list:

Yes	No

Please list all medications that you are taking or attach list: _____

Please list any other health problems: _____

CONFIDENTIAL