PREMIER DERMATOLOGY

PATIENT HISTORY FORM

NAME:_____
DATE:_____
SS#:_____
DOB:_____

Do you have any chronic illnesses? yes_____ no_____
If yes, please explain:

List all prescriptions and non-prescriptions medications or supplements you are currently taking:

Do you have any drug allergies? yes_____ no_____
If yes, please explain:

Do you have a pacemaker? yes_____ no_____ Artificial joint? yes_____ no_____
If yes, please specify:_____

Have you had skin cancer? yes_____ no____
If yes, please explain:

Is there a family history of skin cancer? yes_____ no_____
If yes, was it melanoma? yes_____ no_____

Do you have any chronic or recurrent problems within the following categories? Check all that apply.
Please circle the symptoms you experience.

□**Eyes**: dryness, itching, light-sensitivity	□**Sinuses**: hay fever, allergies, chronic sinus
□**Genitourinary:** genital itch, discharge, burning with urination, Kidney trouble	□**Cardiovascular:** heart trouble, heart murmur, artificial heart valve, mitral valve prolapsed, High Blood Pressure, poor circulation
□**Headaches**: chronic, recurrent migraines	□**Cancer:** what type?_____
□**Ears**: scaling, itching, rash	□**Diabetes**
□**Lungs**: shortness of breath, asthma,	□**Keloids**
□**Nervous system**.: tingling/numb in fingers/toes	□**Joint replacement**
□**Gastrointestinal**: diarrhea, nausea, reflux, colitis/Inflamm. Bowel disease	□**Thyroid Trouble**
□**Mental state**: high stress, anxiety, depression	□**Easy bleeding**
□**Other**:	

Smoking Status: □Not a current tobacco user:
□ 0 Cigarettes per day (non-smoker or < 100 in a lifetime) □ 0 Cigarettes per day (previous smoker)

□Current tobacco user:
□Few (1-3) cigarettes per day □Up to 1 pack per day
□1-2 packs per day □ 2 or more packs per day

Do you drink alcohol? Yes_____No_____ If 'Yes', how much? _____

Would you like your medical provider to perform a whole-body skin exam? Yes___ No___; If "No", what areas of the

body would you like examined? _____

I would like to speak to the aesthetician about skin care products and or cosmetic treatments. Yes____ No_____