Medical History

(Please Print)

Name: _____ Date: _____

Do you scar abnormally e.g. Thick abnormal scar (Keloid)? Yes □ No □

Do you have an abnormal bleeding tendency? Yes □ No □

Have you noticed a change in any spots or "moles" on your face or body? Yes □ No □

Have you had gold injections for Rheumatoid Arthritis? Yes □ No □

List all current medications, ***including over the counter medications*** you are taking:

_____

Do you or anyone in your family have a history of: Melanoma □ Skin Cancer □

Please list all major operations: _____

Please **CIRCLE** any of the following drugs that you are allergic to:

Penicillin, Sulfa, Mycins, Anesthetic (Novocain)

Other drug allergies not listed above_____

Have you ever had X-ray therapy ("Radiation") for a malignancy or skin conditions? Yes □ No □

Please **CIRCLE** if there is a family history of:

Hay fever, Eczema, Asthma, Allergies, Diabetes, Skin cancer,

Other diseases: _____

Please check any of the following you have a history of:

Accutane Therapy		HIV/AIDS	
Anticoagulants/Aspirin		Hives/Urticaria	
Auto Immune Disorder		Hormone Problems	
Cold Sores/Herpes		Laser resurfacing/Dermabrasion	
Dental Filling/Metal pins		Pacemaker	
Diabetes		Recent Cosmetic Surgery	
Heart Disease		Seizures	
Hepatitis		Sensitivity to light	
High blood pressure		Thyroid Disease	

If yes to any of the above, please explain_____