MEDICAL HISTORY FORM

Today's Date ______________

Patient's Name: ________________________________

Birth Date: ______________ ☐ Female ☐ Male

Do You Have Any Medical Allergies? *If yes, please check the appropriate box:* ○ Yes ○ No

☐ Aspirin	☐ Sulfa	☐ Antibiotics	☐ Local anesthetics	☐ Demerol
☐ Penicillin	☐ Codeine	☐ Sedatives	☐ Stimulants	☐ diet pills
☐ Antacids	☐ laxatives	☐ Cold tablets	☐ antibiotic ointments	☐ Tape
☐ Talc powder	☐ contact dermatitis	☐ Hay fever		

Others, please list ________________________________

Are You Allergic To Latex? ○ Yes ○ No

Have you ever had problems with general/local/regional anesthesia? ○ Yes ○ No

Have you taken Zovirax, Famavir, Valtrax, or Homone Supplements? ○ Yes ○ No

Do you smoke cigarettes? ○ Yes ○ No

Have you ever taken Accutane? ○ Yes ○ No **If yes, stop date:** ______________

Have you ever been tested for HIV? ○ Yes ○ No **If yes, date of last test** ______________

Have you tested positive for HIV? ○ Yes ○ No

Are You Currently Taking Any Medications? ○ Yes ○ No

List **all** medications you are currently taking including oral, topical and injection, birth control and non prescription:

Medication	Dose	How Often

List all surgeries and/or hospitalizations you've had:

Surgery/Hospitalization	Date	Complications

Primary Care Physician

Name ______________

Address ______________

City ______________ State ______ Zip ______

Phone: ______________

Are you currently seeing a physician? ○ Yes ○ No

Secondary Care Physician (eg. OB/GYN, Specialty)

Name ______________

Address ______________

City ______________ State ______ Zip ______

Phone: ______________

Specialty ______________

MEDICAL HISTORY (Page 2)

Name: ____________________

For Women Only:

Date last menstrual period started: ____________________

Contraception Method: ____________________

Any problems with your menstrual cycle? ○ Yes ○ No

Is there any chance you could be pregnant? ○ Yes ○ No

If yes, explain ____________________

Are you currently breastfeeding? ○ Yes ○ No

Do you have or have you ever had any of the following illness or ailments?

Acne	☐ Y	☐ N	Fever Blisters/Cold Sores	☐ Y	☐ N	Poikiloderma of Civatte's	☐ Y	☐ N
Anemia	☐ Y	☐ N	Genital Herpes	☐ Y	☐ N	Polycystic Ovary Disease	☐ Y	☐ N
Artificial Joints	☐ Y	☐ N	Glaucoma	☐ Y	☐ N	Psoriasis	☐ Y	☐ N
Arthrisis	☐ Y	☐ N	Hay Fever	☐ Y	☐ N	Radiation Therapy	☐ Y	☐ N
Auto Immune Deficiency	☐ Y	☐ N	Heart Problems/Disease	☐ Y	☐ N	Recent Weight Gain/Loss	☐ Y	☐ N
Bleeding Problems	☐ Y	☐ N	Heart Murmur	☐ Y	☐ N	Rheumatoid Arthritis	☐ Y	☐ N
Blood Clots/Phlebitis	☐ Y	☐ N	Hepatitis or Yellow Jaundice	☐ Y	☐ N	Rheumatic Fever	☐ Y	☐ N
Blood Transfusion Reaction	☐ Y	☐ N	Hernia	☐ Y	☐ N	Rosacea	☐ Y	☐ N
Breathing/Lung Problems	☐ Y	☐ N	High Blood Pressure	☐ Y	☐ N	Thyroid Disease	☐ Y	☐ N
Cancer	☐ Y	☐ N	Hives or Rashes	☐ Y	☐ N	Tumors	☐ Y	☐ N
Cardiac Pacemaker	☐ Y	☐ N	History of Skin Cancer	☐ Y	☐ N	Seizures	☐ Y	☐ N
Connective Tissue Disease	☐ Y	☐ N	Keloid/Excessive Scar	☐ Y	☐ N	Stomach/Bowel Problems	☐ Y	☐ N
Current Infections	☐ Y	☐ N	Kidney Disease/Problems	☐ Y	☐ N	Ulcers	☐ Y	☐ N
CVA (Stroke)	☐ Y	☐ N	Liver Disease/Problems	☐ Y	☐ N	Ultraviolet Light Therapy	☐ Y	☐ N
Diabetes	☐ Y	☐ N	Melasma	☐ Y	☐ N		☐ Y	☐ N
Emphysema	☐ Y	☐ N	Mitral Valve Prolapse	☐ Y	☐ N		☐ Y	☐ N

Have you ever had treatment for varicose or spider veins? If yes, please list:

Type Of Veins	Where On Body	Type of Treatment	When Treated

Does anyone in your family have Varicose Veins? ○ Yes ○ No

Do you have a history of blood clots or phlebitis? ○ Yes ○ No

Are your varicose veins symptomatic? (pain itching, cramping? ○ Yes ○ No

If yes, explain ____________________

Have varicose veins ever caused you to alter your activities? ○ Yes ○ No

MEDICAL HISTORY (Page 3)

Name: ______________________________

I ACKNOWLEDGE THAT I HAVE ANSWERED ALL OF THE ABOVE QUESTIONS TRUTHFULLY & COMPLETELY TO THE BEST OF MY KNOWLEDGE & RECOLLECTION.

Patient Signature ______________________________

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OR You may print this form and bring with you to your appointment.