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Patient Name _____ **Date** ____/ ____/ ____

INFORMATION: *(please complete this section in its entirety)*

Reason for visit? _____

When did this start? When was condition first noticed? _____

Are you allergic to any medications? (*please circle one*) YES NO

If you circled YES, please list medications to which you are allergic:

_____

All medications you are currently taking: _____

_____

Any and all operations you have had: _____

_____

Are you currently scheduled for any upcoming surgeries? (*please circle one*) YES NO

If you circled YES, please list the surgery and expected date of operation:

_____

MEDICAL HISTORY: (*please circle each condition or disorder that applies to you*)

Acne		Glaucoma		Malignant Melanoma
Anemia		Hair Loss		Mitral Valve Prolapse
Arthritis		Hay Fever		Neurological Problems
Asthma		Headaches (chronic)		Psoriasis
Bleeding (excessive)		Heart Problems		Rheumatic Fever
Blood Clots		Hepatitis		Pacemaker
Breathing Disorder		Herpes Simplex (cold sores)		Scarring/Keloids
Bruise Easily		Herpes Zoster (shingles		Skin Cancer
Cancer		High Blood Pressure		STD/Venereal Diseases
Cataracts		HIV		Stroke
Colon/Intestinal Disorders		Hives		Thyroid Disease
Convulsions/Seizures		Infections (chronic)		Tuberculosis
Depression		Kidney Disease		Ulcers
Diabetes		Liver Disease		Varicose Veins
Eczema		Loss of Skin Pigment		Vitiligo
Epilepsy		Lung Disease		Warts
Fainting Spells		Lupus		Wound Healing Difficult

Other Conditions: (please list/explain) _____

_____