

New Patient Medical Information Form

Present Skin Problem: _____

Present Medication: _____

Do you take aspirin or ibuprofen regularly? NO YES, How often? _____

Allergies to medications or anesthetics? NO YES, Please list: _____

PAST AND PRESENT MEDICAL HISTORY

YES NO

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Eczema |
| <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Hives |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin Cancer (Basal Cell Carcinoma & Squamous Cell Carcinoma) |
| <input type="checkbox"/> | <input type="checkbox"/> | Malignant Melanoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Family History of Melanoma |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Dysplastic (Atypical) Moles |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Herpes Infection |

If applicable, are you currently pregnant? _____

Any other major medical problem? _____
