Azalea Skin Treatment Center

Medical History Information

Please take a moment to complete this form. It will become a permanent part of your medical record and will provide better dermatologic care for you. If you are an established patient and you have a new problem, we ask that you fill out a new form. Please update your medications below.

Name _____ Date _____ / _____ / _____
Age _____ Hgt _____ Wgt _____ DOB _____ / _____ / _____ Gender _____
Who is your primary care physician? _____
Pharmacy Name and Phone Number? _____

Problem 1	Problem 2 (time permitting)
What skin problem brought you here today?	What skin problem brought you here today?
Where on your body?	Where on your body?
How long has this been a problem?	How long has this been a problem?
Is it □ itchy □ burning □ painful □ sensitive □ other	Is it □ itchy □ burning □ painful □ sensitive □ other
List treatments that have been used:	List treatments that have been used:
Which ones have been helpful?	Which ones have been helpful?
Has any treatment made this worse?	Has any treatment made this worse?

Have you ever had a reaction to local anesthesia (Novocaine, Lidocaine, or Epinephrine)? □ Yes □ No
Do you have any allergies to medications? _____
If allergic to medications, what symptoms do you have? _____

Please list all medications you are currently taking:
THIS INCLUDES ALL PRESCRIPTIONS, OVER-THE-COUNTER MEDICINES, HERBS AND VITAMINS / MINERALS / DIETARY (NUTRITIONAL) SUPPLEMENTS.

MEDICATION NAME	DOSAGE (Pill size)	FREQUENCY (How many times a day do you take?)	ROUTE OF ADMINISTRATION (How do you take?) oral, injection, topical, drink	Staff Initials	Staff Initials	Staff Initials

(Should you have additional medications, please use separate medication list. Please ask if you have any questions.)

Female Patients: Are you pregnant? □ **Yes** □ **No** □ **N/A** **Breastfeeding?** □ **Yes** □ **No**
What is your current birth control method? (circle one)
abstinent / condoms / hysterectomy / IUD / oral contraceptive / patch / post menopausal / tubal ligation / partner vasectomy / ring/ other: _____

Medical History / Review of Systems: (Circle conditions that you have now or have had in the past)

Allergy to latex
Allergy to local anesthetic
Antibiotics with surgery
Asthma
Bleeding problem
Blood vessel disease
Bowel problems
Cancer
Chest pain
Dental / mouth problems
Depression / anxiety
Decreased thyroid
Diabetes
Difficulty healing wounds
Endocarditis
Eczema
Fever, fatigue, weakness
Hay fever / allergies (seasonal)
Headaches / seizures
Heart disease
Heart valve replacement
High blood pressure
History of Hepatitis B or C
HIV / AIDS
Hives
Joint replacement
Kidney disease
Liver disease
Lung disease
Lupus
Mitral valve prolapse
Muscle / joint ache
Pace maker / defibrillator
Psoriasis
Rheumatic fever
Rosacea
Shortness of breath / cough
Thickened scars
Urinary problems
Visual difficulty
Other: _____

Other major health issues: _____

Patient Skin Cancer History:
Have you ever had skin cancer? _____
□ Basal Cell Carcinoma: Where on body? _____ When treated? _____
□ Squamous Cell Carcinoma: Where on body? _____ When treated? _____
□ Malignant Melanoma: Where on body? _____When treated? _____

Do you have any family history of melanoma? □ Yes □ No If yes, who? _____

Do you use sunscreen? □ Yes □ No SPF Strength _____

Occupation _____
Do you smoke? □ Yes □ No Alcohol Use? □ Yes □ No _____ drinks/wk Illicit Drug Use? □ Yes □ No

Are you interested in receiving more information about the following cosmetic services:
Skin Care Products / Facial Peels / Hair Removal / Leg Veins / Botox / Fillers for Wrinkles / Hair Restoration

Patient / Parent Signature: _____ **Date: _____**

MD / FNP Signature: _____ **Date: _____**

STAFF USE ONLY

Updated:

_____ Patient Initials / Date	_____ Patient Initials / Date	_____ Patient Initials / Date
_____ Provider Initials / Date	_____ Provider Initials / Date	_____ Provider Initials / Date