PATIENT NAME ______________________________ **DATE** ______________

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list below:

____

List all medication you are currently taking (including prescriptions, over-the-counter meds including asprin, herbals, vitamin): ______________________________

____

____

Do you take any blood thinners like asprin, coumadin, plavix, Vitamin E? ☐ Yes ☐ No

Do you have or have you ever had any diseases or conditions of: (Please check all that apply)

- ☐ High Blood Pressure
- ☐ Heart Attack/Angina
- ☐ Heart Murmur
- ☐ Pacemaker
- ☐ Anxiety
- ☐ Mitral Valve Prolapse
- ☐ AIDS/HIV
- ☐ Artificial Valves
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Tuberculosis
- ☐ Blood Clots
- ☐ Sinus Allergies
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Urinary Disease
- ☐ Stomach Ulcers
- ☐ Hepatitis
- ☐ Dialysis
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Fainting
- ☐ Seizures
- ☐ Stroke
- ☐ Migraines
- ☐ Depression
- ☐ Other: ______________________

List any major surgeries: ______________________________

(Women) Are you currently pregnant or nursing? ☐ Yes ☐ No

Have you ever had skin cancer? ☐ Yes ☐ No If yes, explain: ______________________

Has any blood relative had any skin cancer? ☐ Yes ☐ No If yes, explain: ______________________

Do you have any history of any skin diseases? ☐ Yes ☐ No If yes, explain: ______________________

Do you have any problems with healing? ☐ Yes ☐ No If yes, explain: ______________________

Do you keloid or scar easily? ☐ Yes ☐ No If yes, explain: ______________________

SOCIAL HISTORY

Do you drink alcohol? ☐ Yes ☐ No If yes __________ drinks per day/week

Do you use IV drugs? ☐ Yes ☐ No If yes, what? ______________________

Do you smoke? ☐ Yes ☐ No If yes, how much? ______________________

Have you had or been exposed to AIDS/HIV? ☐ Yes ☐ No

PATIENT SIGNATURE ______________________________ **DATE** ______________