Horizon Dermatology
& COSMETIC CENTER

**Patient Name**: _____ **Date**: _____

**What is the primary reason for your visit today**? _____

_____

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 aspirin, herbals, vitamins):

_____

_____

Do you take any blood thinners like aspirin, Coumadin, Plavix, Motrin, Vitamin E? Yes/No

(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 your 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 HIV/AIDS Yes/No

**Physician Signature**_____

**Patient Signature**: _____ Date: _____

## COMPLETE THE MEDICAL HISTORY FORM ON THE FOLLOWING PAGE.