DERMATOLOGY SURGERY AND LASER CENTER
HEALTH HISTORY QUESTIONAIRE

Name: ______________________________ Date: ______________

Address: ____________________ ______________ ________ __________
Street City State Zip Code

Home Phone: ( ) __________ Cell Phone: ( ) __________ Work Phone: ( ) __________

Date of Birth: __________ Age: ________ SS#: ______________

Occupation: ________________ Business Name: ________________

Business Address: ______________ __________ ________ ________
Street City State Zip Code

Martial Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

Email Address: ________________ In Case of Emergency Contact: ______________

Spouse Name: ________________ Spouse's Occupation: ______________

Spouse Work Phone Number: ( ) ______________

Insurance Company: ______________________________

Insured Name: ______________________ Relationship: ______________

Name of Insurance Company: ________________ Phone Number: ( ) ____________

Address: ____

ID #: ______________ Group: ______________ Medicare: ______________

Reason for Visit:

( ) Liposuction
( ) Laser for Scar Revision
( ) Permanent Cosmetics
( ) Fat Transfer
( ) Laser for Pigmentation
( ) Skin Care Program
( ) Botox
( ) Laser for Blood Vessels
( ) Facials
( ) Fillers
( ) Hair Transplantation
( ) Moles & Growths
( ) Vein Treatment/Sclerotherapy
( ) Ambulatory Phlebotomy
( ) Dermatological Surgery
( ) Lip Augmentation
( ) Thermage
( ) Acne Treatment
( ) Laser Hair Removal

Referred By: ______________________ May we acknowledge Referral? ( ) Yes ( ) No

Address: ______________________________________ Phone: ( ) ____________

( ) Dermatologist (Name)______________________
( ) Plastic Surgeon (Name)______________________
( ) Physician (Name)______________________
( ) Magazine/News Paper (Which one?)______________
( ) Website (Which one?)______________________
( ) Friend (Name)______________
( ) Patient (Name)______________
( ) Other______________

Name:_________________________________Age:______Ht.:_________Wt.:_______

Are you in good health?:_______ Are you under the care of a physician?: Yes_____ No______

If Yes, whom?_________________________________ Physician Phone #:_________________

When was your last physical exam?:_______________ Was everything o.k.?: Yes_____ No_____

Please list any drug allergies:____

Are you allergic or have you had a reaction to:

Local Anesthesia	Yes No	Barbiturates, Sedatives or Sleeping Pills	Yes No
Penicillin or other Antibiotics	Yes No	Aspirin	Yes No
Sulfa Drugs	Yes No	Iodine	Yes No
Codeine	Yes No	OTHER_____________________________	

Please list All Medications you are currently taking (include any over the counter medications)

____

Please List Any Current or Past Medical Illnesses with:
Dates:____
Please List all Hospitalizations, injuries or accidents with:
Dates:____
Please List any surgeries (including cosmetic) with:
Dates:____
Any significant hereditary disorders (excessive bleeding):______________________________
Do you smoke?: Yes_____ No_____ If Yes, What type?:_________________Frequently_________
Do you drink?: ( ) None ( ) Occasionally ( ) Moderately ( ) Excessively

Please answer the following questions:

Do you have herpes or cold sore breakouts?	YES NO
Do you have frequent headaches?	YES NO
Do you have asthma or any chronic lung or bronchial conditions?	YES NO
Do you experience recurrent chest pain or shortness of breath?	YES NO
Have you been told you have heart trouble?	YES NO
Do you have any abdominal problems?	YES NO
(Stomach, intestinal, gallbladder, liver, hepatitis)	YES NO
Do you test positive for hepatitis or have you had acute or chronic hepatitis?	YES NO
Any trouble with you kidneys, bladder or reproductive system?	YES NO
Any bone, joint, or muscular trouble?	YES NO
Do you have any chronic skin condition?	YES NO
Do you have any of the following: diabetes, epilepsy, or high blood pressure?	YES NO
Do you have AIDS or are you positive for the AIDS virus?	YES NO
Have you ever had a nervous breakdown?	YES NO
Have you been under the care of a psychiatrist or psychologist?	YES NO
Have you had any marked loss or gain of weight lately?	YES NO
Are you on any special diet or taking diet supplements?	YES NO
Do you bleed or bruise easily?	YES NO
Do the blood vessels in your skin sometimes break without apparent cause?	YES NO
Do you have nose bleeds?	YES NO
Have you ever had any bleeding requiring the attention of a doctor?	YES NO
Have you ever had a blood transfusion?	YES NO
Have you ever had excessive bleeding following surgery or dental work?	YES NO
Have you ever had poor scarring or colloid formation after a surgery or vaccination?	YES NO
Did you have a normal recovery following a prior surgery?	YES NO
Are you extremely sensitive to anesthetics or any medicines?	YES NO
Do you understand that no surgeon can guarantee a good result in any operation that is performed?	YES NO
Do you understand that anyone undergoing any operation, no matter how minor, must assume a certain risk?	YES NO
Have you ever been dissatisfied with the treatment you received from a doctor?	YES NO

If yes, please explain:____