Vitalogy SKINCARE

Patient Medical History

Patient Name: ______________________ **Height:** ______ **Weight**: ______ **DOB**: ______ **Date:** _______

Past Medical History:

Anxiety	☐ Yes	☐ No	Pacemaker	☐Yes	☐No
Asthma/Allergies (respiratory condition)	☐Yes	☐No	Radiation Treatment	☐Yes	☐No
Artificial Joints (hip/knee/shoulder)	☐Yes	☐No	Epilepsy/ Seizures	☐ Yes	☐No
Atrial Fibrillation	☐Yes	☐No	Stent/ Bypass	☐Yes	☐No
Blood thinners	☐Yes	☐No	Stroke	☐Yes	☐No
Depression	☐Yes	☐No	Valve Replacement	☐Yes	☐No
Diabetes	☐Yes	☐No	Weight gain or loss	☐Yes	☐No
GERD	☐Yes	☐No	Pregnant or Planning Pregnancy	☐Yes	☐No
Hearing Loss	☐Yes	☐No	Are you breast feeding	☐Yes	☐ No
HEP/HIV	☐Yes	☐ No	Do you take antibiotics before procedures	☐Yes	☐ No
Hypertension	☐ Yes	☐ No	Yeast infections when taking antibiotics	☐ Yes	☐ No
Keloids (Difficulty healing)	☐ Yes	☐ No	Other __________________________		

Past Surgical History:

Joint Replacement, knee (right, left, bilateral)	☐ Yes	☐ No	Joint Replacement within last 2 years	☐ Yes	☐ No
Joint Replacement, hip (right, left, bilateral)	☐ Yes	☐ No	Skin biopsy	☐ Yes	☐ No
Basal Cell Cancer Surgery	☐ Yes	☐ No	Squamous Cell Carcinoma Surgery	☐ Yes	☐ No
Melanoma Surgery	☐ Yes	☐ No	If Yes, what level/stage ________ Year_____		

Other ______________________________________

Skin Disease History:

Acne	☐ Yes	☐ No	Dry Skin/Eczema	☐ Yes	☐ No	Psoriasis	☐ Yes	☐ No
Blistering Sunburns	☐ Yes	☐ No	Flaking or Itchy Scalp	☐ Yes	☐ No	Poison Ivy	☐ Yes	☐ No
Melanoma	☐ Yes	☐ No	Squamous Cell Cancer	☐ Yes	☐ No	Basal Cell Cancer	☐ Yes	☐ No
Actinic Keratosis	☐ Yes	☐ No	Precancerous Moles	☐ Yes	☐ No	Other ____________________		

General Skin: Are you interested in anti-aging ☐ Yes ☐ No

Are you interested in preventative skin cancer products ☐ Yes ☐ No

Do you wear Sunscreen ☐ Yes ☐ No If yes, what SPF? _________

Regular use of tanning beds/ spray tans ☐ Yes ☐ No Last sunburn/ prolonged sun exposure ______

Do you have any tattoos ☐ Yes ☐ No Have you had a recent full skin exam ☐Yes ☐No

Has anyone in your family had any of the following skin cancers?

Basal Cell Carcinoma	☐Yes	☐No	Squamous Cell Carcinoma	☐Yes	☐No
Malignant Melanoma	☐Yes	☐No	If Yes, what level/stage _______ Year_____		

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Please list your drug allergies:

____ ____

____ ____

Please list current prescription and over the counter medications that you take (including any facial topicals):

_____________________Dose:_____Frequency:____ _____________________Dose:_____Frequency:____

_____________________Dose:_____Frequency:____ _____________________Dose:_____Frequency:____

_____________________Dose:_____Frequency:____ _____________________Dose:_____Frequency:____

Social History:

Never Smoked ☐ Quit: former smoker ☐ Smokes less than daily ☐ Smokes Daily ☐

Alcohol use:

(Male Patients Only) How many times in the past year have you had more than 5 drinks in one day?

None ☐ Less than 2 times ☐ More than 2 times ☐

(Female Patients Only) How many times in the past year have you had more than 4 drinks in one day?

None ☐ Less than 2 times ☐ More than 2 times ☐

Not sexually active☐ Sexually active☐

Cosmetic Dermatology:

Do you have history of facial surgeries ☐ Yes ☐ No If yes, when ___________

Have you had cosmetic injectables (botox or fillers) ☐ Yes ☐ No If yes, when was your last injection ________

History of Accutane use ☐ Yes ☐ No If yes, when ____________

Have you had skin rejuvenation treatments ☐ Yes ☐ No Do you have a history of Cold Sores ☐ Yes ☐ No

Are you interested in any of these treatments? ☐ Yes ☐ No Do you have metal implants ☐ Yes ☐ No

Do you have a history of any autoimmune disease ☐ Yes ☐ No

Please list any other health-related conditions not previously identified:

____ ____

Reason for today's visit (chief complaint):

____

Are you currently under another physician/ technician for the care of your skin? ☐ Yes ☐ No

Pharmacy Information:

Name __________________________ Phone Number ___________________________

Who is your Primary Care Physician:

Name __________________________ Phone Number ___________________________

Parent/ Guardian Information (if patient is a minor):

Name ____ Phone Number(s) _______________________________________