River Region DERMATOLOGY & LASER | SKINCEUTICALS ADVANCED CLINICAL SPA

Patient Name: _____ Visit Date ___/___/___

Date of Birth: _____

Patient Medical History

Past Medical History: (Please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ GERD
- ☐ Hearing loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Renal Disease
- ☐ Thyroid Problems
- ☐ Seizures
- ☐ Stroke

Other_____

Past Surgical Procedures:

- ☐ Yes Please list: _____
- ☐ No

Skin Disease History: (Please check all that apply)

- ☐ Acne
- ☐ Actinic keratosis
- ☐ Basal Cell Carcinoma
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking/ itching scalp
- ☐ Melanoma
- ☐ Precancerous moles
- ☐ Psoriasis
- ☐ Squamous cell carcinoma
- ☐ None

Do you wear sunscreen? Yes No If yes, what SPF? _____
Do you use or have a history of using a tanning salon? Yes No
Do you have a family history of melanoma? Yes No If yes, who? _____

Medication *Please list all medications. Attach list, if necessary.*	**Allergies** *Please list all allergies.*	**Smoking Status** *Please check one*	**Alcohol Use** *Please check one*
1.	1.	☐ Unknown	☐ Less than 1 drink
2.	2.	☐ Currently smokes	☐ 1-2 drinks per day
3.	3.	☐ Past history of smoking	☐ 3 or more drinks per day
4.	4.	☐ Never smoked	☐ Never

Family History: (Please circle one)

Melanoma Yes No Relative:	**Psoriasis** Yes No Relative:	**Hair Loss** Yes No Relative:	**Unknown**
Skin Cancer Yes No Relative:	**Eczema** Yes No Relative:	**Lupus:** Yes No Relative:	**Other**

Alerts: (Please circle one)

Are you currently pregnant or trying to get pregnant? Yes No