Medical Questionnaire

Name _____ **Date** _____ **Date of Birth** _____

Do you have or have you ever had any of the following?

Yes	No	
☐	☐	Skin Cancer / Melanoma
☐	☐	Acne
☐	☐	Cold sores
☐	☐	Keloids / Bad scars
☐	☐	Eczema / Skin rashes
☐	☐	Difficulty with wound healing
☐	☐	Difficulty with skin infections
☐	☐	Psoriasis
☐	☐	Asthma / Hay fever / Hives / Sinus problems
☐	☐	Rheumatic Fever
☐	☐	Heart Disease
☐	☐	High blood pressure
☐	☐	Heart murmur / Mitral Valve Prolapse
☐	☐	Artificial joint, heart valve, or prosthesis
☐	☐	Heart burn / Ulcers /Gastritis / Reflux
☐	☐	Kidney Disease
☐	☐	Glaucoma
☐	☐	Diabetes
☐	☐	Tuberculosis
☐	☐	Blood-bourne Infections
☐	☐	Autoimmune disease (Lupus, rheumatoid arthritis)
☐	☐	Blood transfusions Dates: _____
☐	☐	Hepatitis – B or C (please circle)
☐	☐	HIV
☐	☐	Surgery/hospitalizations Operation Date Hospital _____ _____
☐	☐	Other _____

Have any blood relatives ever had any of the following?

☐	☐	Skin Cancer
☐	☐	Melanoma
☐	☐	Abnormal moles
☐	☐	Asthma / Hay fever
☐	☐	Eczema / Skin rashes
☐	☐	Diabetes
☐	☐	Psoriasis
☐	☐	Other skin disease _____

Signature:_____

Are you allergic to any medications?

(Please list) If none, check here ☐

_____

_____

_____

_____

Are you currently taking or using any medications or vitamin / mineral supplements?

(Please list) If none, check here ☐

_____

_____

_____

_____

_____

Other Questions	**Yes**	**No**
Are you currently taking Accutane or have you used Accutane in the past?	☐	☐
Are you in good health?	☐	☐
Are you now under a physician's care?	☐	☐

If so, for what conditions?

_____

_____

_____

Name of your primary care physician

_____

	Yes	**No**
Do you smoke?	☐	☐
Do you drink?	☐	☐
Do you sunbathe or use tanning booths?	☐	☐
Do you need antibiotics before surgery or dental work?	☐	☐
Do you bleed easily for a long time after a cut or extraction?	☐	☐
Do you use sunscreen?	☐	☐

Females only

Are you pregnant?	☐	☐
Are you nursing?	☐	☐
Do you take birth control pills?	☐	☐

Name of birth control pills_____

Date of last menstrual period _____/_____/_____

DATE PROVIDER REVIEWED:	**PROVIDER INITIALS:**
_____	_____
_____	_____
_____	_____

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