WASHINGTON DC DERMATOLOGY

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(One block from Farragut North, Two blocks from Farragut West Metro)

MEDICAL HISTORY FORM

DATE: _____

PATIENT NAME: _____DOB: _____

ADDRESS: _____ ___ CITY:_____ STATE:_____ ZIP: _____

CELL PHONE #:_____ EMAIL:_____

1) List all medications you are currently taking (including OTC, vitamins, herbals, & topicals):

_____

_____

2) List any allergies:

_____

_____

3) Have you ever had any of these health conditions in the past or present? (Please check all that apply and provide additional information in the space provided)

Cancer _____(type) □
Hepatitis □
Spinal injury □
Metal implants □
Psychiatric disorder □
Seizure disorder □
Any eye problems □
Headaches (chronic) □
High blood pressure □
Immune disorders □
Diabetes □
Arthritis □
Asthma/Breathing problems □
Neuromuscular disorders □
Hormone imbalance □
Fever blisters/Cold sores □
Thyroid condition □
Bleeding problems □
Skin diseases/skin cancer _____(type) □
Any active infection □
Keloid scarring □
HIV/AIDS □
Heart problem □

List any other medical conditions not listed above: _____

4) Have you had any surgeries, including plastic surgery? □ No □ Yes, explain:

_____

5) Have you ever had □ Botox, or □ Fillers,? If so, when was your last treatment?_____
What product did you receive? _____
Did you have any problems with the treatment? If so, explain.

_____

6) Are you pregnant or trying to become pregnant? □ No □ Yes
7) Are you breast-feeding? □ No □ Yes
8) Do you smoke? □ No □ Yes
9) Do you drink alcohol? □ No □ Yes If yes, how much do you drink? _____/day _____/week
10) Do you bruise easily? □ No □ Yes
11) Do you have any issues with scarring or hyperpigmentation? □ No □ Yes

I understand the information on this form is essential to determine my cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature_____ **Date**_____