

DERMATOLOGIC
L A S E R C E N T E R

Online Patient Medical History Form

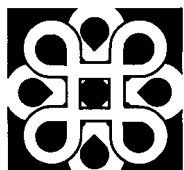
Name:	Date of Birth:
Social Security #:	Race:
Patient Height: Weight:	Currently Pregnant: Yes No N/A

Past Medical History - Have you had any of the following:

Medical History	NO	YES	If yes, please give date
Aid/HIV			
Arthritis			
Asthma			
Cancer			
Depression			
Fever Blisters			
Tuberculosis			
Diabetics			
Thyroid Disease			
Hepatitis			
High Blood Pressure			
Low Blood Pressure			
Heart Disease			
Ulcers			

Major Surgeries:

Hospitalization :	Date of Occurrence:



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Serious Illness:

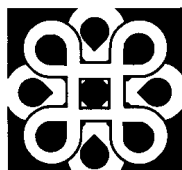
Serious Illness/Accident:	Date of Occurrence:

Drug Allergies:

Allergy Name:	Reaction:

Medications:

Medication Name:	Length of Time Taken:



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Family History:

	NO	YES	Afflicted Family Member
Acne			
Autoimmune Disorder			
Cancer			
Diabetes			
Endocrine Disease			
Hemophilia			
Skin Cancer			
Skin Disease			

Social History:

Smoking History:	Denies(no)	Currently Smoking	Quit
Alcohol Usage:	Yes	No	
Recreational Drug Use:	Yes	No	
Have you Ever Used Tanning Beds:	Yes	No	
Do have problems with Scarring:			
Do you have problems with Bruising or Bleeding:			
Do you use Sunscreen:	Daily	Rarely/never	Always if sunny Sometimes if sunny
Occupation:			