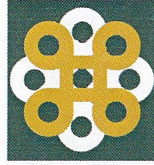

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Patient Information Sheet:

Mr. Mrs. Ms. Miss. Dr. Sister Father (circle one)	Email:
Name:	Date of Birth:
Address:	City: State: Zip:
Home Phone ( )	Cell Phone ( )
Social Security #:	Race: Sex:
Patient Height: Weight:	Currently Pregnant: Martial Status:

Emergency Contact:

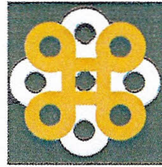
Name:	Relationship:
Home Phone:	Work/Cell Phone:

Employment Information:

Employed by:
Occupation:
Business Address:
City,State,Zip:
Manager's Name:

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			
Diabetics			
Fever Blisters			
Heart Disease			
Hepatitis			
High Blood Pressure			
Low Blood Pressure			
Thyroid Disease			
Tuberculosis			
Ulcers			



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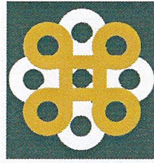
Family History:

	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:				



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Major Surgeries:

Hospitalization :	Date of Occurrence:

Serious Illness:

Serious Illness/Accident:	Date of Occurrence:

Drug Allergies:

Allergy Name:	Reaction:

Medications:

Medication Name:	Length of Time Taken: