Dermatology of Santa Fe, PC

AESTHETIC MEDICAL HISTORY FORM

Last Name:______________________ First Name:______________________

Date of Birth:________________ Male:_____ Female:_____

Mailing Address:____

City:____________________ State:__________ Zip Code:____________

Email:________________________ Phone number:____________________

Family Doctor:___________________ Pharmacy:_____________________

Emergency Contact:________________ Phone Number:_______________

How did you hear about us: _____________________________________

What type of treatments are you interested in today?______________________

____

1. Do you have allergies to medications, foods, latex or other substances? YES / NO

   *Please list:*____

2. Do you smoke? YES / NO Do you consume alcohol? YES / NO

3. Do you have ANY current or chronic medical conditions?

   Please disclose history of multiple sclerosis, myasthenia gravis, diabetes, autoimmune disorders or any immunosuppression, blood disorders, clotting disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders or any other conditions or illnesses.

   Please list:____

4. Do you have ANY current or chronic skin conditions? YES / NO

   Please disclose history of cold sores, herpes, vitiligo, eczema, melasma, psoriasis, allergic dermatitis, skin cancer, any disease affecting collagen including Ehlers-Danlos syndrome, scleroderma, or any other skin condition?

   *Please list:*____

5. Are you currently under a doctor's care: YES / NO

   *If so, for what?*____

6. Do you take ANY medications (prescriptions or non-prescriptions), including vitamins and herbal supplements? YES / NO

Please list:____

7. Are there any topical products (both medical and non-medical) that you use on your skin on a regular basis?

Please list:____

8. Are you taking oral steroids (prednisone, dexamethasone etc.)? YES / NO

9. Do you have a pacemaker or external defibrillator? YES / NO

10. Do you have any metal implants under the area being treated? YES / NO

11. Do you have a history of Herpes/cold sores in the area being treated? YES / NO

12. Do you have any open sores or lesions? YES / NO

13. Have you have radiation therapy in the area being treated? YES / NO

14. Do you have a history of keloid or hypertrophic scar formation? YES / NO

15. In the last 6 months, have you used any of the following mediations? YES / NO

Anticoagulants or blood-thinning medications, sun-sensitizing medications or anti-inflammatory medications?

*List product and date use:*__________________________________

16. Have you ever been treated with Botulinums (Botox, Dysport, etc)? YES / NO

If so, when and how many times?: ______________________________

*How many units have you gotten in the past?*________________________

17. Have you ever been treated with dermal fillers? YES / NO

If so, when and what kind?__________________________________

18. Have you had any other cosmetic procedures in the last 24 months? YES / NO

Please describe: _______________________________________

19. Are you pregnant or breastfeeding? YES / NO

Patient Signature:_____________________________ Date:__________