MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Have you ever had Skin Cancer? Y / N **If yes, was it Basal Cell, Squamous Cell, or Melanoma**? (Circle all that apply)

Where was is located? How and when was it treated? _____

Do you have a family history of Basal Cell, Squamous Cell or Melanoma? _____

Do you have dry skin, eczema, or psoriasis? **Y / N** – Do you have a family history of dry skin, eczema, or psoriasis? **Y / N**

Do you have any chronic medical conditions **or** skin conditions? (Please list all) _____

_____

Please list all current medication (including creams): _____

_____

Are you currently on any blood thinners? **Y / N**

Please list all drug or food allergies (including latex, lidocaine and adhesives): _____

_____

Do you have any artificial joints or valves? **Y / N** Do you have a pacemaker or defibrillator? **Y / N**

Do you take antibiotics prior to dental procedures? **Y / N**
Please list any prior surgeries you have had (Surgery/Month/Year): _____

_____

Do you or have you ever smoked? **Current / Former / NON** How many cigarettes a day do you smoke? _____
Do you have a history of drug use? **Y /N**
Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

If 'Yes': How often did you have six or more drinks on ONE occasion in the past year?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily
If 'yes': How many drinks did you have on a typical day when you were drinking in the past year?
☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more
If 'yes'; How often did you have a drink containing alcohol in the past year?
☐ Never ☐ Monthly or less ☐ 2 to 4 times a month ☐ 2 to 3 times per week ☐ 4 or more times a week

Have you ever received a pneumonia Vaccine? If yes, date (MO/ YEAR) _____

Have you had the flu shot within the last year? If yes, date (MO/ YEAR) _____

Do you Exercise? **Y / N** Do you have any body piercings? **Y / N**
Do you have any tattoos? **Y /N** Have you ever used a tanning bed? **Y / N**
Are you interested in cosmetic procedures? **Y / N** (please provide your email) _____
Have you ever had Botox or other cosmetic fillers? **Y / N** If yes, what did you have? _____
Do you currently have a skin care regimen? **Y /N** If yes, what are you using? _____

_____

Are you receiving improvement from current regimen? **Y / N** Do you wear sunscreen? **daily / when exposed / never**
Are you interested in a cosmetic consultation with our Aqua Medical Spa? **Y / N**