

SOUTHEASTERN DERMATOLOGY GROUP, P.A.

Dermatology Specialists of Alabama, Florida, Georgia, and Mississippi
877-231-DERM (3376)

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 it 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**
