ADVANCED DERMATOLOGY & COSMETIC CENTER

Patient's Name (First, Middle, Last) _____

MEDICATIONS

Please list all medications, vitamins, or herbal supplements that you take:

Medication Name	Dose	How Often

MEDICAL HISTORY

Please list all current medical problems:

_____
_____
_____
_____
_____

Do you require antibiotics prior to surgery or dental work? ○ YES ○ NO
Do you have an implanted cardiac device (i.e. pacemaker, valve)? ○ YES ○ NO
Do you have a history of excess scarring or keloids? ○ YES ○ NO
Do you have a history of excess bleeding? ○ YES ○ NO
Are you nursing? ○ YES ○ NO
Are you pregnant or trying to get pregnant? ○ YES ○ NO

ALLERGIES

Please list any known allergies (i.e. medications, food, seasonal):

_____
_____
_____

Are you allergic to latex? ○ YES ● NO

SURGICAL HISTORY

Please list any past surgeries and approximate dates:

_____
_____
_____
_____
_____

FAMILY HISTORY

Do any immediate family members have any of the following?

List Relative(s) including Maternal / Paternal

Excessive Bleeding _____
Excessive Scarring or Keloids _____
Tuberculosis _____
Heart Disease _____
Cancer _____
Arthritis _____
Non Melanoma Skin Cancer _____
Melanoma _____
Diabetes _____

SOCIAL HISTORY

Please be honest. This can affect medication selection and dosing.

Do you drink alcohol? ◯ **YES** ◯ **NO**
If so, how often and how much? _____

Do you use recreational drugs? ◯ **YES** ◯ **NO**
If so, how often and how much? _____

Do you use sunscreen? ◯ **YES** ◯ **NO**

Do you use tobacco? Please circle one. **Currently use** **Formerly used** **Never used**
If you currently use or formerly used tobacco, how often and how much?_____

What are your hobbies?

_____
_____
_____