Patient Name ____ Date _________________

Pregnant? Yes No Planning a pregnancy? Yes No Oral Contraceptives? Yes No

Please describe how sensitive your skin is ____

Please list any topical creams, prescription creams, or over the counter products that you have used in the last 3 months?

____

Daily Medications & Recently Taken Meds	Mo/Yr Taking	When Stopped or changed?	Changed to: (Nurse will complete)

Taking Aspirin? Yes No Taking Vitamin E? Yes No

Allergies to medications?____

Allergies to environmental sources? ____

Please **circle** any medical conditions **you** have or may have had; **underline** any medical conditions **family members** have or may have had:

Diabetes	Hepatitis	Bleeding Tendency	Stomach Ulcer
Cancer	Pacemaker	Heart Disease	Rhuematic Fever
Asthma	Cataracts	Kidney Disease	Eczema/Psoriasis
Arthritis	Lupus	Convulsions	High Blood Pressure
Glaucoma	Tuberculosis	Phlebitis/Blood Clot	HIV Positive

Sun Allergy Rash Other (please list) ____

Family History of Skin Cancer?____

Please list your surgeries ____

Problems with anesthetics? Yes No How sensitive are you to anesthetics and medications? _______________________

Any additional comments?