

PATIENT MEDICAL HISTORY

Patient: _____ Date of Birth _____ / _____ / _____ Age: _____

How did you hear about us? Yellow Pages Charlotte Wkly Skirt Sign Other: _____

Primary Care Physician: _____ Were you referred by this physician? Yes No

Name of Referring Doctor's Group: _____ City: _____ State: _____

Medication Allergies: NONE SULFA PENICILLIN Other (list): _____

Medication you are taking (include OTC, herbal, vitamins): NONE Aspirin Coumadin OTHER (List): _____

Pharmacy: _____ Address: _____ Phone _____ - _____ - _____

MAJOR SURGERY: NONE Appendix Gallbladder Heart Hysterectomy Joint Replacement (year: _____)

Other (list): _____

Do you have now or have you ever had diseases or conditions of: (please check YES or NO)

Arthritis/Joint Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hearing Loss	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Artificial Joint	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Exposed to HIV/AIDS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Asthma, Hayfever	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Heart Disease/Attack	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Bladder Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Heart Murmur	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Blood Clots	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hepatitis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cancer	<input type="checkbox"/> YES	<input type="checkbox"/> NO	High Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cataracts/Glaucoma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Irregular Heartbeat	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Convulsions/Epilepsy	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Kidney Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Liver/Gall Bladder Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Eczema	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Pacemaker/Defibrillator	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Emotional Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Thyroid Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
GI/Stomach Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	TB/Lung Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Other Medical problems, Please List: _____

SKIN:

Yes No Have you personally had skin cancer?

Yes No Have you had a pre-cancer?

Yes No Do you have a personal history of any specific skin disease? Eczema Psoriasis Rosacea Acne
Other (list): _____

Yes No Do you have problems with skin or wound healing?

Yes No Do you develop keloids or thick scars after surgery?

Yes No Do you bleed easily?

SOCIAL:

Yes No Do you drink alcohol? Yes No Do you use tobacco products?

FAMILY HISTORY: Has anyone in your family had:

Yes No Melanoma if yes, who: _____ Eczema Psoriasis Hay Fever Asthma

Yes No Other skin cancer (if yes, who): _____

CHIEF COMPLAINT: Acne Warts Mole Rash Eczema Growth Other

How Long have you had this problem? _____ Where on the body? _____

Are your symptoms: Mild Moderate Severe Is today a Good Day Average Day Bad Day

Briefly Describe your symptoms: _____

Prior TreatmentsL: _____

As part of his routine examination, Dr Darst performs a full skin examination to look for skin cancer.

Yes No Would you like a Full Skin Examination today?

COSMETIC INTEREST

Can we provide you with further information on any of the following services?

- Botox (for facial wrinkles)
- Latisse (for longer fuller lashes)
- Skin Care Products
- Peels / Facial Rejuvenation
- Facial Rejuvenation with injectable Fillers (Juvederm, etc)
- Skin Tag / Mole Removal
- Brown Spot Reduction / Removal
- Leg Spider Vein Treatment
- Facial Spider Vein Treatment
- Hair Loss Treatment
- Laser Hair Removal
- Other