

AZ DERMATOLOGY

1821 N. Trezell Rd. Suite. #5, Casa Grande, AZ 85222

Office: (520) 374-2462 Fax: (520) 374-2467

Medical Questionnaire

Name _____ Date _____ Date of Birth _____

Do you have or have you ever had any of the following?

Yes No

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Skin Cancer / Melanoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Acne / Accutane |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold sores |
| <input type="checkbox"/> | <input type="checkbox"/> | Keloids / Bad scars |
| <input type="checkbox"/> | <input type="checkbox"/> | Eczema / Skin rashes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty with wound healing |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty with skin infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Psoriasis |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma / Hay fever / Hives / Sinus problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur / Mitral Valve Prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial joint, heart valve, or prosthesis |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart burn / Ulcers / Gastritis / Reflux |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood-bourne Infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune disease (Lupus, rheumatoid arthritis) |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusions |
| | | Dates: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis – B or C (please circle) |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgery/hospitalizations |
| | | Operation Date Hospital |
| | | <input type="text"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Have any blood relatives ever had any of the following?

- | | | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Skin Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Melanoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal moles |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma / Hay fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Eczema / Skin rashes |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Psoriasis |
| <input type="checkbox"/> | <input type="checkbox"/> | Other skin disease _____ |

Are you allergic to any medications?

(Please list)

If none, check here

Are you currently taking any medications or vitamin / mineral supplements?

(Please list)

If none, check here

Other Questions

Yes No

Are you in good health?

Are you now under a physician's care?

If so, for what conditions?

Primary Care Physician

Do you smoke?

Do you sunbathe or use tanning booths?

Do you need antibiotics before surgery

or dental work?

Do you bleed easily for a long

time after a cut or extraction?

Females only

Are you pregnant?

Are you nursing?

Do you take birth control pills?

Name of birth control pills _____

Date of last menstrual period ____/____/____

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Aesthetic Skin Health History

Name _____ Age _____ Date ____ / ____ / ____

What are your main concerns about the appearance of your skin?

Red Spots Brown Spots Rosacea Fine Wrinkles Deep Wrinkles Sun Damage Tone & Texture Acne

Enlarged Pores Oily Spots Dry Skin Scarring Facial Veins Leg Veins Unwanted Hair Other _____

Please list skin care products used: (brand, how often)

Cleanser

Toner

Rejuvenation

Moisturizer

Sunblock

Make Up

Self Tanner

Bleaching Agent

Any known skin allergies? (cosmetics, sunblock, etc.)

Have you ever had any skin care procedures? (facials, peels, lasers, etc.)

Have you ever had any injectable procedures (Botox, collagen, etc.)

Have you ever had permanent make up applied? Y N What area(s)? _____

What skin care products/procedures are you interested in?

How did you hear about us? MD Referral Family/Friend Magazine Yellow Pages Postcard Other _____