weissmann mehrel
dermatology * mohs & cosmetic surgery

Medical History

Patient Name:_____ Date of Birth:_____ Today's Date:_____
Referring Doctor: _____ Family Physician:_____
Reason for today's visit:_____
Are you allergic to any medications: ☐ Yes ☐ No What kind of allergic reaction:_____
☐ Local Anesthetics _____ ☐ Aspirin _____ ☐ Penicillin _____ ☐ Sulfa _____
☐ Codeine _____ ☐ Erythromycin _____ ☐ Tetracycline_____
☐ Others, please list_____
List all medications you are currently taking: (if needed, list additional meds on back):
1._____ 2._____ 3._____
4._____ 5._____ 6._____

General:
Do you have now, or have you ever had, any of the diseases or conditions following:
(Please check Yes or No)

	Yes	No		Yes	No
Bronchitis	☐	☐	High Blood Pressure	☐	☐
Emphysema	☐	☐	Chest Pain	☐	☐
Asthma	☐	☐	Heart Attack	☐	☐
Chronic/Morning Cough	☐	☐	Heart Murmur	☐	☐
COPD	☐	☐	Irregular Heart Beat	☐	☐
Pneumonia	☐	☐	Pacemaker/AICD	☐	☐
Tuberculosis	☐	☐	Congestive Heart Failure	☐	☐
Diabetes	☐	☐	Glaucoma/Eye Conditions	☐	☐
Thyroid	☐	☐	Arthritis/Join Deformity	☐	☐
Kidney Problems	☐	☐	Convulsions, Epilepsy or Seizures	☐	☐
Bladder Problems	☐	☐	Fainting	☐	☐
Ulcers	☐	☐	Cancer	☐	☐
Stomach/Bowel Problems	☐	☐	Hay Fever	☐	☐
Hepatitis or Yellow Skin	☐	☐	Gallbladder Problems	☐	☐
HIV / AIDS	☐	☐	Blood Clots	☐	☐
Low Blood Pressure	☐	☐	Artificial Heart Valve	☐	☐
Stroke	☐	☐			

Please answer the following questions:
Do you smoke? ☐ Yes ☐ No If YES, how much: _____
Do you drink alcohol? ☐ Yes ☐ No If YES, _____ per day
(Women only) Are you pregnant? Due Date:_____ ☐ Yes ☐ No
Do you have artificial joint(s)? ☐ Yes ☐ No
Do you require antibiotics prior to surgery? ☐ Yes ☐ No
Have you ever had dental anesthesia (Lidocaine or Novacaine)? ☐ Yes ☐ No
Any bad reaction: ☐ Yes ☐ No
List any other disease or condition we should know about:_____
List surgical procedures you have had:_____

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Dermatological History

Has anyone in your **family** ever had:			Family Member:
Melanoma	yes ☐	no ☐	_____
Non-Melanoma Skin Cancer	yes ☐	no ☐	_____
Unusual Moles	yes ☐	no ☐	_____
Psoriasis	yes ☐	no ☐	_____
Allergic Skin Conditions (Hives. Eczema. Dermatitis)	yes ☐	no ☐	_____
Respiratory Allergies (Asthma. Hay Fever. Sinus Problems)	yes ☐	no ☐	_____
Severe Acne	yes ☐	no ☐	_____
Sunlight Sensitivity	yes ☐	no ☐	_____
Autoimmune Diseases (Lupus. Scleroderma. Raynaud's. Dermatomyositis)	yes ☐	no ☐	_____

Have **you** ever had:

Melanoma	yes ☐	no ☐
Non-Melanoma Skin Cancer	yes ☐	no ☐
esPrecancerous Keratos	yes ☐	no ☐
Unusual Moles	yes ☐	no ☐
Psoriasis	yes ☐	no ☐
Allergic Skin Conditions (Hives. Eczema. Dermatitis. Drug Rash)	yes ☐	no ☐
Respiratory Allergies (Asthma. Hay Fever. Sinus Problems)	yes ☐	no ☐
Acne	yes ☐	no ☐
Sunlight Sensitivity	yes ☐	no ☐
Autoimmune Diseases (Lupus. Scleroderma. Raynaud's. Dermatomyositis)	yes ☐	no ☐
Cold Sores (Fever Blisters. Herpes Labialis)	yes ☐	no ☐

How would you best describe your reaction to sun exposure:

Always burn, never tan ☐ often burn, sometimes tan ☐ rarely burn, always tan ☐
Never burn, tan darkly ☐

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Skincare and Cosmetic History

How would you most accurately describe your skin?
Normal ☐ Dry ☐ Oily ☐ Combination/T-zone ☐
Sensitive ☐ Sun-damaged ☐ Environmentally-damaged ☐ Acne-prone ☐

Are you concerned about any of the following?
Blackheads ☐ Whiteheads ☐ Breakouts ☐ Acne-scars ☐ Large pores ☐
Pigmentation ☐ Uneven color ☐ Broken capillaries ☐ Redness ☐
Wrinkles ☐ Loss of skin-tone ☐ Sagging skin ☐ Jowls ☐

Have you ever had any of the following procedures?
Facelift ☐ Browlift ☐ Eyelid surgery ☐ Liposuction ☐
Collagen ☐ Fat-transplant ☐ Silicone ☐ Other filler injections ☐_____
Botox® ☐ Microdermabrasion ☐ Glycolic peels ☐ Chemical peels ☐
Laser resurfacing ☐ Laser hair removal ☐ Intense pulsed light®(photofacials) ☐

Would you like information on any of these procedures or alternatives ? yes ☐ no ☐
Which one(s) ? _____

Are you currently using ?			What brand ?
Cleanser	yes ☐	no ☐	_____
Toner	yes ☐	no ☐	_____
Moisturizer	yes ☐	no ☐	_____
Sunblock	yes ☐	no ☐	_____
Eye Cream	yes ☐	no ☐	_____
Night Cream	yes ☐	no ☐	_____
Mask	yes ☐	no ☐	_____
Vitamin C products	yes ☐	no ☐	_____
Retinoids (Retin-A, Tazorac, Renova, Avita. Differin, Retinol)	yes ☐	no ☐	_____
Alpha hydroxy products (glycolic acid, lactic acid. salicylic acid)	yes ☐	no ☐	_____
Skin lightener (hydroquinone, kojic acid)	yes ☐	no ☐	_____
Other anti-aging products (TNS etc.)	yes ☐	no ☐	_____

Are you currently using body cosmetics such as moisturizers and sunblocks ? yes ☐ no ☐
Which brands ? _____