



COSMETIC DERMATOLOGY OF GEORGETOWN

**PLEASE PRINT**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First M.I.

Reason for today's visit: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Current Medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**CIRCLE IF YOU HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING CONDITIONS:**

- |                     |                 |                 |
|---------------------|-----------------|-----------------|
| Skin Cancer         | Chest Pain      | Arthritis       |
| Eczema              | Pacemaker       | Depression      |
| Psoriasis           | Asthma          | Anxiety         |
| Hives               | Allergies       | Seizures        |
| STD                 | Chronic Cough   | Fainting        |
| HIV                 | Emphysema       | Alcohol Problem |
| Hepatitis           | Bronchitis      | Drug Use        |
| High Blood Pressure | Diabetes        |                 |
| Heart Attack        | Thyroid Disease | Other: _____    |

**PLEASE ANSWER THE FOLLOWING QUESTIONS**

Have you had any surgeries? If yes, please list. \_\_\_\_\_

\_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much per week? \_\_\_\_\_

Do you bleed easily, take aspirin daily or other blood thinners? \_\_\_\_\_

Have you had a blood transfusion? If yes, when? \_\_\_\_\_

Do you have artificial joints? \_\_\_\_\_

Are you pregnant or breast feeding? \_\_\_\_\_

Circle if there is a family history of: Skin Cancer Eczema Asthma Seasonal Allergies