



# Medical Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

Yes No

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

### Have any blood relatives ever had any of the following?

- Skin Cancer
- Melanoma
- Abnormal moles
- Asthma / Hay fever
- Eczema / Skin rashes
- Diabetes
- Psoriasis
- Other skin disease \_\_\_\_\_

Signature: \_\_\_\_\_

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### Are you allergic to any medications?

(Please list) If none, check here

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

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

(Please list) If none, check here

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

### Other Questions

Yes No

Are you currently taking Accutane or have you used Accutane in the past?

Are you in good health?

Are you now under a physician's care?    
If so, for what conditions?

\_\_\_\_\_  
\_\_\_\_\_  
Name of your primary care physician  
\_\_\_\_\_

Yes No

Do you smoke?

Do you drink?

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?

Do you use sunscreen?

### Females only

Are you pregnant?

Are you nursing?

Do you take birth control pills?

Name of birth control pills \_\_\_\_\_

Date of last menstrual period \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>DATE PROVIDER REVIEWED:</b>	<b>PROVIDER INITIALS:</b>
_____	_____
_____	_____
_____	_____