

Account #

Insight Dermatology

9878 Hibert Street, Suite 100 San Diego, CA 92131 858-693-3000

PATIENT MEDICAL HISTORY

Last Name: _____ First Name: _____ Date: ____/____/____

Reason(s) for visit (list up to 3, include location, duration, symptoms, treatment):

- 1. _____
- 2. _____
- 3. _____

Do you have any allergies to medications, latex or skin creams? No Yes
If yes, please list: _____

List all medications, creams and supplements you are currently taking: _____

List all your medical conditions: _____

List any surgeries you have had: _____

PLEASE FILL IN BUBBLES COMPLETELY:

Past Medical History

- Have you ever had skin cancer? Yes No
- If so, please indicate type: Basal Cell Squamous Cell Melanoma Other
- Have you ever had Eczema or Atopic Dermatitis? Yes No
- Do you have a history of asthma? Yes No
- Have you had seasonal allergies or hay fever? Yes No
- Have you ever had cold sores (Herpes Simplex Infection)? Yes No
- For Women: Are you pregnant? Yes No
- Are you breast feeding? Yes No
- Are you using Birth Control? Yes No
- If Yes, please indicate method(s): Oral Contraceptive Pills Condoms
 Depo Provera Implanted Device Other

PLEASE FILL IN BUBBLES COMPLETELY:

Family History

Please indicate if any of your siblings, parents or children have had the following:

- Basal Cell Skin Cancer Squamous Cell Skin Cancer Melanoma
 Non-skin Cancer Eczema Asthma Hay Fever
 Thyroid Disease Autoimmune Disease (e.g. Lupus or Rheumatoid Arthritis)
 None of the above

Surgical History

Please indicate if you have had any of the following procedures:

- Skin Cancer Surgery Mohs Surgery
 Botox Chemical Peel Acne Scar Treatment Hair Transplant
 Sclerotherapy (vein injections) Filler (e.g. Restylane, Juvederm, Radiesse) FAMI
 Facelift Blepharoplasty Liposuction Laser Surgery
 None of the above

Review of Systems

- Do you have trouble with wound healing? Yes No
Do you tend to bleed excessively? Yes No
Do you have a tendency to form hypertrophic scars and keloids? Yes No
Have you had allergic reactions to bandages and tape? Yes No
Do you have enlarged lymph nodes? Yes No
Are you immunosuppressed e.g. have HIV/AIDS or history of lymphoma or leukemia? Yes No
Do you have a prosthetic hip or knee joint? Yes No
Do you have a pacemaker/defibrillator? Yes No
Do you take aspirin or coumadin or other anticoagulants? Yes No
Do you have mitral valve prolapse? Yes No
Do you have a history of blood clots or emboli? Yes No
Have you ever fainted or become light-headed with minor surgical procedures? Yes No

Would you like information on (please circle):

- | | |
|-------------------------------------|--|
| Botox treatments | Fillers (Restylane, Juvederm, Radiesse) |
| Laser Hair Removal | Sclerotherapy for Varicose and Spider Veins |
| IPL (Fotofacial) | Chemical Peels (e.g. Jessner's, Glycolic Acid, TCA) |
| Skincare Products (e.g. anti-aging) | Scar Treatments (e.g. acne scars) |
| Lattise (for Eyelash Lengthening) | Removal of Age Spots, Sun Spots, Brown Spots, Moles, Skin Tags |

Signature: _____

Date: _____