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

PLEASE FILL IN BUBBLES COMPLETELY:

Family History
Please indicate if any of your siblings, parents or children have had the following:
O Basal Cell Skin Cancer O Squamous Cell Skin Cancer O Melanoma
O Non-skin Cancer O Eczema O Asthma O Hay Fever
O Thyroid Disease O Autoimmune Disease (e.g. Lupus or Rheumatoid Arthritis)
O None of the above

Surgical History
Please indicate if you have had any of the following procedures:
O Skin Cancer Surgery O Mohs Surgery
O Botox O Chemical Peel O Acne Scar Treatment O Hair Transplant
O Sclerotherapy (vein injections) O Filler (e.g. Restylane, Juvederm, Radiesse) O FAMI
O Facelift O Blepharoplasty O Liposuction O Laser Surgery
O None of the above

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