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Account #	Insight Dermatology 9878 Hibert Street, Suite 100 San Diego, CA 92131 858-693-3000	
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## **PATIENT MEDICAL HISTORY**

Last Name:	F	irst Name:			)ate:	_//.	
Reason(s) for visit (list u	-						
2							
3							
Do you have any allergions of the second sec					No		Yes
List all medications, creataking:	• •	•					
List all your medical con							
List any surgeries you ha							
Please indicate your pha		_			-		er if
PLEASE FILL IN BUB	BLES COMPI	LETELY:					
Past Medical History	•						
Have you ever had skin If so, please indicate typ Have you ever had Ecze Do you have a history of Have you had seasonal a Have you ever had cold	e: O Basal C ma or Atopic D fasthma? allergies or hay sores (Herpes	Cell O Squar Dermatitis? O O Yes O No v fever? O Simplex Infecti	Yes O No Yes O No		na C	Other	
For Women: Are you pro	•		O. N.				
Are you using Pirth Con		O Yes	J NO				
Are you using Birth Conf If Yes, please indicate m		O No O Oral Contrac	antiva Dilla	O Cond	doms		
ii 103, picase maicate m		O Depo Provei	•			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 Squ	iamous Cell Skin Cancer O Melanoma
O Non-skin Cancer O Eczema	O Asthma O Hay Fever
O Thyroid Disease O Autoimm	une 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 Mo	
O Botox O Chemical Peel	<del></del>
	•
	Filler (e.g. Restylane, Juvederm, Radiesse) O FAMI
O Facelift O Blepharoplas	ty O Liposuction O Laser Surgery
O None of the above	
Daview of Contents	
Review of Systems	12. O.V O.N.
Do you have trouble with wound heal	
Do you tend to bleed excessively?	
Do you have a tendency to form hype	•
Have you had allergic reactions to bar	
Do you have a history of immunosupp	oression, lymphoma or leukemia? O Yes O No
Do you have a history of or exposure	to HIV, hepatitis B or C? O Yes O No
Do you have a prosthetic hip or knee	joint? O Yes O No
Do you have a pacemaker/defibrillato	r? O Yes O No
Do you take aspirin or coumadin or ot	her anticoagulants? O Yes O No
Do you have mitral valve prolapse?	O Yes O No
Do you have a history of blood clots o	r emboli? O Yes O No
•	t-headed with minor surgical procedures? O Yes O No
5	0 to 1 to 2 to 1 to 1 to 1 to 1 to 1 to 1
Would you like information on (please	e circle):
Botox treatments	Fillers
IPL (Fotofacial)	Microneedling for acne scars, wrinkles, skin rejuvenation
Laser Resurfacing	PRP Injections for Hair Loss
Chemical Peels	Laser Hair Removal
Leg Vein Treatment	Kybella for chin/neck fullness
Skincare Products (e.g. anti-aging)	Latisse (for Eyelash Lengthening)
Signature:	Date: