Magnolia
DERMATOLOGY & AESTHETICS

Medical History Form

Patient Name _____ Date of Birth_____

Past Medical History

☐ High blood pressure ☐ Diabetes ☐ Atrial Fibrillation ☐ Anxiety or Depression

☐ Thyroid Disorders ☐ Heart Attack ☐ Kidney disease ☐ Arthritis

☐ Hearing loss ☐ High Cholesterol ☐ Asthma. ☐ Stroke

☐ COPD ☐ HIV/AIDS

Cancer (type):_____

Organ Transplantation (liver, kidney etc): _____

Other: _____

History of radiation treatment? Yes / No
Please describe: _____

Do you have a pacemaker? Yes / No
Defibrillator? Yes / No
Do you require antibiotics prior to surgical procedures? Yes / No
Do you have problems with bleeding? Yes / No
If yes, please describe:_____

Are you pregnant or trying to become pregnant? Yes / No
Currently breastfeeding? Yes / No

Prior Surgical History

History of joint replacement _____

Other surgical history _____

_____

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Past Dermatologic History

Personal history of skin cancer:

☐ Basal cell ☐ Squamous cell ☐ Melanoma ☐ Merkel Cell

Other _____
Please specify body location, date and treatment _____

Family History of Skin cancers (first degree relatives only): Yes / No
Family history of melanoma? Yes / No
Please specify _____

☐ Blistering sunburns

Do you currently tan at a tanning salon? Yes / No

Prior tanning bed use: Yes / No

History of Accutane use: Yes / No (if yes, please provide date(s) of treatment)_____

Current Medications

_____
_____
_____
_____

Allergies _____

Are you allergic to any of the following?
☐ Adhesive ☐ Lidocaine ☐ Topical ☐ Antibiotics ☐ Latex

Do you develop a rapid heartbeat with epinephrine? Yes / No

Social History

Do you smoke and frequency? Yes / No _____

Do you consume alcohol and frequency? Yes / No_____