Name:_____ Date:_____

HIGH BLOOD PRESSURE	YES	NO
HEART DISEASE	YES	NO
SEIZURES	YES	NO
LIVER DISEASE	YES	NO
KIDNEY DISEASE	YES	NO
VENEREAL DISEASE	YES	NO
CANCER	YES	NO

If YES, are you currently undergoing chemotherapy or other type of treatment?

_____

Have YOU or a family member had:

			family member
SKIN CANCER	YES	NO	_____
MELANOMA	YES	NO	_____
DIABETES	YES	NO	_____
PSORIASIS	YES	NO	_____
ECZEMA	YES	NO	_____
ASTHMA	YES	NO	_____

Do YOU have:

DIFFICULTY WITH HEALING WOUNDS	YES	NO
EXCESSIVE BLEEDING WHEN CUT	YES	NO
OVERGROWN SCARS	YES	NO

Have you previously been diagnosed or treated for any skin diseases by another Dermatologist?

if YES, please explain_____

_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____

_____

_____

_____

_____

_____

ARE YOU ALLERGIC TO LOCAL ANESTHETICS?_____

_____

_____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?_____

_____

_____

_____

_____

Do you have a pacemaker?

_____ Yes _____ No

ARE YOU CURRENTLY BEING TREATED FOR ANY INFECTIOUS DISEASES?

if YES, please explain

_____

_____

_____

_____

FOR WOMEN ONLY

ARE YOU PREGNANT OR PLANNING A PREGNANCY?	YES	NO
DO YOU TAKE BIRTH CONTROL PILLS?	YES	NO