MD Skincare and Laser
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Patient Medical History Form

Name: _____ Age: _____ Sex: M F

What is the purpose of your visit today?

[ ] Laser Hair Removal
[ ] Skin Rejuvenation
[ ] Brown Spots
[ ] Acne
[ ] Wrinkles/Fine Lines
[ ] Other _____

Please list all your medications and dosage, including over-the-counter meds and vitamins:

_____ _____

_____ _____

Please list any allergies to food or medications:

_____ _____

_____ _____

Past Medical History (check all that apply)

[ ] High Blood Pressure
[ ] Diabetes
[ ] High Cholesterol
[ ] Heart Attack
[ ] Heart Arrhythmia
[ ] Congestive Heart Failure
[ ] Stroke / TIA
[ ] Pacemaker/defibrillator
[ ] Cancer, Type: _____
[ ] Chemotherapy/Radiation
[ ] Sarcoidosis
[ ] Multiple Sclerosis
[ ] Lupus
[ ] Scleroderma
[ ] Autoimmune Disease
[ ] Vitiligo
[ ] Herpes/Cold Sores
[ ] Polycystic Ovarian Syndrome
[ ] Blood Clots/Bleeding Disorders
[ ] Lymphedema
[ ] Thyroid Disease
[ ] Varicose Veins
[ ] Pregnant/Trying to Get Pregnant
[ ] Other _____

Are you currently taking any blood thinning medications? [ ] yes [ ] no

If yes, please list the medications and the conditions for which they are prescribed:

_____

Past Surgical History

_____ _____

_____ _____

Family History

Has any blood relative ever had any of the following?

High Blood Pressure	[ ] Yes	[ ] No	
Diabetes	[ ] Yes	[ ] No	
High Cholesterol	[ ] Yes	[ ] No	
Heart Attack	[ ] Yes	[ ] No	
Stroke	[ ] Yes	[ ] No	
Cancer	[ ] Yes	[ ] No	If yes, what type? _____
Psychiatric Disorder	[ ] Yes	[ ] No	If yes, what type? _____

Social History

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widow(er)

Occupation: _____

Habits	Heavy	Moderate	Light	None
Alcohol	[ ]	[ ]	[ ]	[ ]
Coffee	[ ]	[ ]	[ ]	[ ]
Tobacco	[ ]	[ ]	[ ]	[ ]
Sleep	[ ]	[ ]	[ ]	[ ]

Have you ever been hospitalized or been under medical care for any psychiatric illness, alcohol or drug rehab? [ ] yes [ ] no

If yes, please explain: _____

For women only

Are you currently pregnant or breast feeding? [ ] yes [ ] no

Are you currently using birth control pills? [ ] yes [ ] no

What was the first date of your last period? _____

Are your periods regular? [ ] yes [ ] no

If no, please explain: _____

Review of Systems

Please check the items that apply.

Head and Neck
[ ] Eye pain
[ ] Eye drainage
[ ] Hearing loss
[ ] Ear pain
[ ] Ear drainage
[ ] Ringing in ears
[ ] Sinus pain or pressure
[ ] Allergies
[ ] Nasal congestion
[ ] Sore Throat
[ ] Runny nose
[ ] Sneezing
[ ] Frequent nosebleeds
[ ] Bleeding gums
[ ] Dental problems
[ ] Sores in mouth
[ ] Hoarseness
[ ] Swelling in neck

Energy
[ ] Fatigue
[ ] Heat or cold intolerance
[ ] Generalized weakness
[ ] Lethargy
[ ] Restlessness
[ ] Hyperactivity

Cardiac
[ ] Chest pain or pressure
[ ] Racing heartbeat
[ ] Palpitations
[ ] Swelling of ankles

Pulmonary
[ ] Waking up at night short of breath
[ ] Daytime sleepiness
[ ] Snoring
[ ] Stop breathing during sleep
[ ] Short of breath when lying flat
[ ] Shortness of breath
[ ] Wheezing
[ ] Persistent cough
[ ] Coughing up blood

Digestive
[ ] Abdominal pain
[ ] Nausea/vomiting
[ ] Heartburn
[ ] Vomiting blood
[ ] Pain with swallowing
[ ] Difficulty swallowing
[ ] Blood in stool
[ ] Black bowel movements
[ ] Constipation
[ ] Diarrhea

Skin
[ ] Skin rash
[ ] Dry skin
[ ] Changing mole
[ ] Joint pain or swelling
[ ] Skin ulcer or non-healing sore
[ ] Lumps or bumps
[ ] Excessive sweating

Emotional & Mental
[ ] Anxiety
[ ] Depression
[ ] Impaired sexual function
[ ] Mood swings
[ ] Irritability
[ ] Poor Concentration

Genital Urinary
[ ] Burning with urination
[ ] Excessive urination
[ ] Incontinence of urine
[ ] Urinary urgency
[ ] Urinary frequency
[ ] Getting up to urinate at night
[ ] Weakened urine stream
[ ] Blood in urine

Neurological
[ ] Numbness or tingling
[ ] Slurred speech
[ ] Loss of consciousness
[ ] Loss of vision
[ ] Loss of balance
[ ] Seizures
[ ] Double vision
[ ] Paralysis
[ ] Tremor
[ ] Severe headaches
[ ] Dizziness

Other Symptoms
[ ] Unexplained weight loss/gain
[ ] Trouble sleeping
[ ] Excessive thirst
[ ] Fever and chills

My signature below warrants that I have completed this questionnaire truthfully and accurately. My records will be kept confidential and will only be shared with staff. My written consent is required for any sharing of information outside of Medical Weight Loss and Wellness.

Print Name: _____

Signature: _____ Date: _____