Name: _____ **Date**: _____

MEDICATIONS:

_____

_____

Are you taking: ◊ ASPIRIN ◊ BLOOD THINNER ◊ ASPIRIN LIKE PRODUCTS

Birth Control Pills ◊ YES ◊ NO Birth Control Implants ◊ YES ◊ NO

ALLERGIES TO: **Medications** **Topicals** **Foods**

_____

_____

Allergy to Neomycin: ◊ YES ◊ NO
Allergy to Xylocaine: ◊ YES ◊ NO
Allergy to Lidocaine: ◊ YES ◊ NO
Allergy to Latex: ◊ YES ◊ NO
Allergy to Epinephrine: ◊ YES ◊ NO

PAST SURGERY HISTORY:

Artificial Hip/Knee: ◊ YES ◊ NO
Artificial Heart Valve/Hx of Mitral Valve Prolapse: ◊ YES ◊ NO
OTHER: _____

PAST MEDICAL HISTORY:
Diabetes: ◊ YES ◊ NO
Gastro Disease / Ulcer: ◊ YES ◊ NO
Thyroid Disease: ◊ YES ◊ NO
Liver Disease: ◊ YES ◊ NO
High Blood Pressure: ◊ YES ◊ NO
Communicable disease / Hepatitis / TB/ Syphillis / HIV: ◊ YES ◊ NO
Glaucoma: ◊ YES ◊ NO

PAST DERMATOLOGIC HISTORY:

SKIN CANCER: ◊ YES ◊ NO
Type: _____ Location/When: _____
Skin Disease or condition: _____
FAMILY HISTORY OF SKIN CANCER/MELANOMA: ◊ YES ◊ NO
Type of relation:_____
Pregnant: ◊ YES ◊ NO Breast Feeding: ◊ YES ◊ NO
Language Spoken: _____ Referred by: _____