Patient Identifying Info

First Name: _____

Middle Name: _____

Last Name: _____

Gender: M F

Date of Birth: _____/_____/_____

SSN: _____

Patient Contact Information

E-mail: _____

Home Phone: _____

Mobile Phone: _____

Office Phone: _____

Patient Address Information

Address: _____

_____

_____

City: _____

State, Zip: _____

Office Use Only

Pharmacy: _____

Insurace Company: _____
Policy #: _____
Group #: _____

FOUNTAIN of YOUTH

Medical History Form

Name: _____ Date: _____

Why are you seeing us today? _____

_____

(Circle One)

Skin Type I: Always burn, never tan

Skin Type II: Always burn, sometimes tan

Skin Type III: Sometimes burn, always tan

Skin Type IV: Never burn, always tan

Skin Type V: Moderately pigmented (*Hispanic, Asian, Middle Eastern)*

Skin Type VI: Black

When were you last exposed to the sun? _____

tanning bed/spray tan? _____

Do you use chemical sun tanning lotions? Y / N

Do you use any Alpha Hydroxy or Retin A products? Y / N

Are you pregnant? Y / N

Do you smoke? Y / N

PLEASE LIST YOUR PRIMARY CARE PHYSICIAN

NAME	SPECIALTY	CITY, STATE	DATE LAST SEEN

LIST ANY OTHER PHYSICIANS YOU SEE

NAME	SPECIALTY	CITY, STATE	DATE LAST SEEN

MEDICAL HISTORY

Have you or members of your family had any of the following:

Condition	You	Family
High Cholesterol		
Heart Disease/Attack		
Rheumatic Fever		
High Blood Pressure		
Stroke		
Blood Clots		
Asthma		
Tuberculosis		
Diabetes		
Thyroid Problems		
Liver Disease		
Hepatitis		
Gallstones		
Arthritis		
HIV/AIDS		
Kidney/Bladder Problem		
Anemia		
Blood Transfusion		
Bleeding Disorder		
Breast Disease		
Breast Cancer		
Ovarian Cancer		
Colon Cancer		
Birth Defects		
Genetic/Inherited		

OTHER MEDICAL HISTORY:

_____

_____

_____

PREVIOUS PROCEDURES/SURGERIES

YEAR	OPERATION	HOSPITAL	COMMENTS

CURRENT PRESCRIPTION MEDICATIONS

(INCLUDE PRESCRIPTION LOTIONS/TOPICALS)

NAME	DOSAGE	TIMES PER DAY	HOW LONG?

MEDICATION ALLERGIES

NAME	REACTION

FOOD/TOPICAL ALLERGIES

NAME	REACTION