Patient Name:______________________ Date:____________________

Age:_____________ Sex: Male/Female

NEW PATIENT MEDICAL HISTORY

Are you currently pregnant, breastfeeding or trying to conceive?

Medications, including over the counter medications, vitamins, and herbal supplements:

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

Anticoagulant therapy (blood thinners)? Yes / No
If Yes, what Drug?(Aspirin, Plavix, Coumadin) _________________________

Allergies to medications, latex or Epinephrine: List the specific types of reaction (i.e. hives, rash, diarrhea.)

Past Surgeries (i.e. joint/heart valve replacements):

Do you need to Pre medicate? Yes/No

Pacemaker, Defibrillator or Heart Murmur? Yes/No

History of Hepatitis B, Hepatitis C Yes/No

History of HIV (Human Immunodeficiency Virus, AIDS) or TB? Yes/No

History of or current use of Tanning Beds? Yes/No

Family History of Skin Cancer? (List type i.e. basal cell carcinoma, squamous cell carcinoma, malignant melanoma)

Personal History of Skin Cancer? (List type, treatment, and year treated)