Aesethetic Surgery & Dermatology of Cherry Creek

Medical History Form

Name: ______________________________ Today's Date: ____________

Date of Birth: ______________________________

YOUR Medical History (Check all that apply):

- [ ] Allergies or Hay Fever
- [ ] Arthritis
- [ ] Asthma
- [ ] Autoimmune Disorder
- [ ] Bleeding Disorders
- [ ] Blood Clots
- [ ] Cancer or history of – Which? _______
- [ ] Depression/Anxiety
- [ ] **Diabetes- Which type?** ____________
- [ ] Difficulty healing/keloids
- [ ] Exposure to someone with Tuberculosis/Tb
- [ ] Hearing loss
- [ ] **Heart attack/Stroke/CAD**
- [ ] **Heart disease, failure or irregular beat**
- [ ] Hepatitis- Which Type? ____________
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] History of positive blood transfusion(s)
- [ ] History of positive PPD or Tuberculosis (TB)
- [ ] HIV/AIDS
- [ ] Hives
- [ ] Immune suppression, including transplant pt
- [ ] Irregular menstruation or PCOS
- [ ] Kidney Disease
- [ ] Liver Problems
- [ ] **Lung Disorder, including COPD**
- [ ] Migraines/Headaches
- [ ] Neurological Disorder, i.e. seizure
- [ ] Thyroid Problems- Which? __________

- [ ] **Melanoma** (location & details) ______________
- [ ] Squamous Cell Carcinoma (location) ______________
- [ ] Basal Cell Carcinoma (location) ______________
- [ ] Skin cancer- not sure what type
- [ ] Actinic keratoses (precancers)
- [ ] Abnormal or precancerous moles
- [ ] Eczema, dry skin or sensitive skin
- [ ] **Psoriasis** Prior biologic therapy? Y or N ______

Past Surgery(ies):

____

____

List any other MEDICAL/SKIN PROBLEMS:

____

____

____

____

Do you have a history of blistering sunburns? No [ ] Yes [ ]

Do you wear sunscreen? No [ ] Yes [ ] If yes, what SPF# ___ How often _________

Do you use or have you used tanning beds? No [ ] Yes, Past [ ] Yes, Current [ ]

Do you have any immediate family members with skin cancer or history of? No [ ] Yes [ ]

If Yes;

- which family member(s)? ______________
- what type of skin cancer, if known, i.e. basal cell carcinoma, squamous cell carcinoma, malignant melanoma, or uncertain? ____________

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List of MEDICATIONS (please include ALL medications including birth control, over-the-counter medications, vitamins, herbal supplements and topical medications).
If none, write 'NONE':

Medication:	Dosage/how often:	What condition(s) you take medication for:
________________	__________	________________________________
________________	__________	________________________________
________________	__________	________________________________
________________	__________	________________________________

ALLERGIES, including to latex or medication(s): ☐ No ☐ Yes, please list below and explain reaction(s):

____

Do you use tobacco products? No ☐ Yes ☐ **Current smoker/Former smoker/Other:** __________

Do you drink alcohol? No ☐ Yes ☐ **How many drinks per day?** __________

Do you use recreational drugs? No ☐ Yes ☐ Drug/frequency __________________
(*including marijuana products*)

Immunizations [*data collection is for Centers for Medicare & Medicaid Services (CMS)*]:
Did you receive the influenza (flu) vaccine for the current/most recent flu season? No ☐ Yes ☐
Have you ever received the pneumonia (aka pneumococcal, Prevnar) vaccine? No ☐ Yes ☐

REVIEW OF SYSTEMS (See separate page, check all that apply):

ALERTS (Check all that apply):

	pregnancy or planning a pregnancy		**Cold sores or history of cold sores (HSV)**
	currently breast feeding		**MRSA**
	allergy to adhesive		**Hepatitis B**
	allergy to topical antibiotic ointments		**Hepatitis C**
	allergy to lidocaine		**HIV positive**
	rapid heartbeat with epinephrine		**West Africa: Travel or Contact**
	artificial heart valve		**Ebola Risk: Fever >= 100.4 degrees (F) / 38.0 degrees (C)**
	artificial joints within past two years		**Ebola Risk: Resided or Traveled To Country with wide-spread Ebola transmission in the last 21 days**
	defibrillator		**Ebola Risk: Contact with an Ebola Patient without proper protective equipment in the last 21 days**
	pacemaker		**Ebola Risk: Headaches, weakness, muscle pain, vomiting, diarrhea, abdominal pain, and/or hemorrhage**
	premedication prior to procedures		
	blood thinners		**NONE OF ABOVE**
	fainting with injections		