Aesthetic 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		