PATIENT NAME: _____ **DATE:** _____

AGE: _____ **BIRTHDATE:** _____ **REFERRED BY:** _____

PHARMACY: _____ **PHARMACY PHONE #:** _____

<<IF YOU HAVE PRESCRIPTION COVERAGE, PLEASE PRESENT YOUR CURRENT RX CARD>>

Please note: If any changes to your pharmacy are made it is the patients responsibility to notify our office.

Are you allergic to any medications? _____ Please specify: _____

Do you have any other allergies? _____ Please specify: _____

Please list any medications you are currently taking: _____

_____

_____

_____

List major surgeries you have had (include year): _____

List any serious illnesses you have had: _____

Please check (√) if any of the following apply:

	PERSONAL HISTORY	FAMILY HISTORY
Acne		
Accutane Treatment		
Eczema		
Psoriasis		
Dry/Brittle Fingernails		
Liver Disease		
Blood Disorders		
Diabetes		
Skin Cancer: Type?		

Have you ever had anything removed from your skin? **If yes, please specify:** _____

_____

Have you ever used a tanning booth on a regular basis? _____

Have you ever used Retin-A? _____ Alpha-Hydroxy Acid products (i.e. glycolic acid)? _____

Do you currently smoke? _____ How much? _____

Do you drink alcohol beverages? _____ How much? _____

IF PATIENT IS A MINOR:

I hereby authorize follow-up medical treatments by the physician in my absence. I understand that I would be notified prior to any surgical procedures. _____

Signature of Parent or Legal Guardian **Date**