

Account #

**Insight Dermatology**

10672 Wexford Street, Suite 205 San Diego, CA 92131 858-693-3000

**PATIENT MEDICAL HISTORY**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason(s) for visit (list up to 3, include location, duration, symptoms, treatment):

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

Do you have any allergies to medications or skin creams? No                      Yes  
If yes, please list: \_\_\_\_\_

List all medications, creams and supplements you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

List all your medical conditions: \_\_\_\_\_  
\_\_\_\_\_

List any surgeries you have had: \_\_\_\_\_  
\_\_\_\_\_

**PLEASE FILL IN BUBBLES COMPLETELY:**

**Past Medical History**

- Have you ever had skin cancer?             Yes     No
- If so, please indicate type:     Basal Cell     Squamous Cell     Melanoma     Other
- Have you ever had Eczema or Atopic Dermatitis?     Yes     No
- Do you have a history of asthma?     Yes     No
- Have you had seasonal allergies or hay fever?     Yes     No
- Have you ever had cold sores (Herpes Simplex Infection)?     Yes     No
- For Women: Are you pregnant?     Yes     No
- If you are nursing, are you breast feeding?     Yes     No
- Are you using Birth Control?     Yes     No
- If Yes, please indicate method(s):     Oral Contraceptive Pills     Condoms  
 Depo Provera     Implanted Device     Other

PLEASE FILL IN BUBBLES COMPLETELY:

Family History

Please indicate if any of your siblings, parents or children have had the following:

- Basal Cell Skin Cancer       Squamous Cell Skin Cancer       Melanoma  
 Non-skin Cancer       Eczema       Asthma       Hay Fever  
 Thyroid Disease       Autoimmune Disease (e.g. Lupus or Rheumatoid Arthritis)  
 None of the above

Surgical History

Please indicate if you have had any of the following procedures:

- Skin Cancer Surgery       Mohs Surgery  
 Botox       Chemical Peel       Acne Scar Treatment       Hair Transplant  
 Sclerotherapy (vein injections)       Filler (e.g. Restylane, Juvederm, Radiesse)       FAMI  
 Facelift       Blepharoplasty       Liposuction       Laser Surgery  
 None of the above

Review of Systems

Do you have trouble with wound healing?     Yes     No

Do you tend to bleed excessively?     Yes     No

Do you have a tendency to form hypertrophic scars and keloids?       Yes     No

Have you had allergic reactions to bandages and tape?     Yes     No

Do you have enlarged lymph nodes?     Yes     No

Are you immunosuppressed e.g. have HIV/AIDS or history of lymphoma or leukemia?     Yes     No

Do you have a prosthetic hip or knee joint?     Yes     No

Do you have a pacemaker/defibrillator?     Yes     No

Do you take aspirin or coumadin or other anticoagulants?       Yes     No

Do you have mitral valve prolapse?     Yes     No

Do you have a history of blood clots or emboli?     Yes     No

Have you ever fainted or become light-headed with minor surgical procedures?     Yes     No

Would you like information on (please circle):

- |                                    |   |
|------------------------------------|---|
| Botox treatments                   | Fillers (Restylane, Juvederm, Radiesse)             |
| Scar treatments (e.g. acne scars)  | Chemical peels (e.g. Jessner's, glycolic acid, TCA) |
| Spider and varicose vein treatment | Mesotherapy (fat-dissolving injections)             |

Signature: \_\_\_\_\_

Date: \_\_\_\_\_