Cosmetic Surgery & Dermatology of Issaquah, Inc.

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PATIENT HISTORY

PLEASE COMPLETE ALL INFORMATION

Date:______________________

Name: ____ ❑ Male ❑ Female Date of Birth:______________________

Primary Physician:____

Referring Physician:____

What problem brings you to our office today?

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Have you had any previous therapy for this problem? ❑ Yes ❑ No If yes, please describe.

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Do you have any other health problems? ❑ Yes ❑ No If yes, please list.

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Do you have any allergies or sensitivities to medications or foods? ❑ Yes ❑ No If yes, please list.

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Does your religion restrict blood transfusions in emergency situations? ❑ Yes ❑ No

Please check the appropriate boxes. Do you have any history of:

1. History of cancer	❑ Yes	❑ No	6. Biopsies or surgery	❑ Yes	❑ No
2. Family history of cancer	❑ Yes	❑ No	7. Severe sunburn	❑ Yes	❑ No
3. Hepatitis	❑ Yes	❑ No	8. Scar formation	❑ Yes	❑ No
4. Positive AIDS antibody test	❑ Yes	❑ No	9. Changing moles	❑ Yes	❑ No
5. Blood Transfusions	❑ Yes	❑ No	10. Pacemaker	❑ Yes	❑ No

If you checked “Yes” to any of the above questions, please describe including dates (use back if necessary).

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