Dermalase
Dr. Kathryn Wood
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Patient Medical History

Patient's Name:____ _Date of Birth:________________ Email:___________________________

Address:____ City:___________________________ State:________ Zip:______________

Best Phone Number to Reach You:______________________________ Alternative Phone Number:_________________________________

Employer:____ Occupation:______________________________ Work Phone:__________________

Person to contact in an emergency:____
(Name, Address, and Phone #)

How did you hear about us?____

Reason for consultation:____

Are you currently under a physician's care?________ Specify:____

HAVE YOU EVER BEEN DIAGNOSED WITH:

	Yes	No		Yes	No		Yes	No
Diabetes:	( )	( )	Heart Murmur:	( )	( )	Phlebitis:	( )	( )
Keloids:	( )	( )	High Blood Pressure:	( )	( )	Allergies:	( )	( )
Bleeding Disorder:	( )	( )	Thyroid Disease:	( )	( )	Hepatitis:	( )	( )
Mitral Valve Prolapse:	( )	( )						

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

Yes	No		Yes	No		Yes	No	
( )	( )	Abnormal Heart Condition	( )	( )	Prolonged Bleeding	( )	( )	Cold Sores
( )	( )	Diabetes	( )	( )	Corneal Abrasions	( )	( )	Cancer
( )	( )	High or Low Blood Pressure	( )	( )	Eye Surgery or Injury	( )	( )	Hemophilia
( )	( )	Circulatory Problems	( )	( )	Blepharoplasty (eyelid Surgery)	( )	( )	"Dry Eye"
( )	( )	Fainting Spells/Dizziness	( )	( )	Visual Disturbances	( )	( )	Epilepsy
( )	( )	Herpes Simplex	( )	( )	Tumors/Growths/Cysts	( )	( )	Cataracts
( )	( )	Chemotherapy/Radiation	( )	( )	Are you pregnant?	( )	( )	Hepatitis
( )	( )	Do you use tobacco products?	( )	( )	Do you wear contact lenses?	( )	( )	Glaucoma
( )	( )	Are you using any eye drops or other ocular medications?						
( )	( )	Have you ever experienced hyperpigmentation from an injury?						
( )	( )	Are you currently taking aspirin or ibuprofen?						

List all medications you are currently taking (including Retin A, Glycolic Acid, and Accutane):

____

____

List any drug, makeup, skin, or food allergies (i.e., soaps/cleansing creams):____

Does your medication prohibit exposure to sun or light? ____________________________________

Have you been on Accutane in the last 9 months_________ Laser resurfacing in the last year? __________

Are you pregnant? ______ If so, how long? ____

Have you ever been tested for HIV_______ Results? ______________________________________

Are you prone to herpes breakouts or cold sores? _______________________________________

What is you natural hair color? ___________________________ currently, your hair is (natural / colored)

Have you recently undergone a skin peel or microdermabrasion? ____________________________

Is your present skin condition normal or abnormal? ______________________ Oily or Dry? ____________

When did you last tan your skin? ______________________ Sun, tanning booth, or creams? _________

When was your last eye exam:_____/_____/______ – Examining Physician: _______________________

Going back three generations, what is your ethnic background? ____________________________

Fitzpatrick Skin Test: Please circle one of the following that describes your skin type:

A. Type I – Always burns, never tans. Red or light blonde hair, light eyes. (White)

B. Type II – Sometimes tans, mostly burns. (White)

C. Type III – Sometimes burns, mostly tans. Also known as "Olive" complexion. (White/Asian)

D. Type IV – Rarely burns, almost always tans. Also known as "Olive" complexion. (Moderate Brown)

E. Type V – Moderately pigmented. (Indian, Hispanic, etc.). (Dark Brown)

F. Type VI – African American, black skin color. (Black)

Patient's Signature:___________________________________ **Date**:_____________