Advanced Associates in Dermatology

28517 Spring Trails Ridge Suite 110, Spring, TX 77386. Phone: 281-385-8189 Fax: 281-203-5037

DERMATOLOGY MEDICAL HISTORY FORM

Today's Date: _____

Patient First Name: _____ Patient Last Name: _____

Date of Birth: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

Social Security #: _____ Driver's License #: _____

Spouse Name or Responsible Party: _____Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

Social Security #: _____ Driver's License #: _____

(In case if emergency please contact)

Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Cosmetic Questionnaire

Are you interested in being added to our cosmetic database to receive emails for special promotions? ☐ **Yes** ☐ **No**

Please check your areas of interest:

☐ **Skin Care Products** ☐ **Mineral Make-up** ☐ **Fillers Botox** ☐ **Fine lines/Wrinkles**

☐ **Facial Veins** ☐ **Brown Spots** ☐ **Facial Texture/Tone** ☐ **Facial Redness/Rosacea**

☐ **Hair Reduction** ☐ **Blotchy Skin** ☐ **Chemical peels** ☐ **Scarring** ☐ **Other** _____

How did you hear of Dr. Soares? ☐ **Internet** ☐ **Magazine** ☐ **Your outside sign** ☐ _____

Referring Physician: _____ **Physician Phone:** _____

Address: _____ City: _____ State: _____ Zip: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Allergies to medication: _____ Reaction: _____

Current medications: - **(topical or oral)**

1.	6.	11.
2.	7.	12.
3.	8.	13.
4.	9	14.
5.	10.	15.

Family Medical History:_____

_____

Past Medical History: (Medical conditions, Hospitalizations, Surgeries) _____

_____

Have you had skin cancer?	Yes ☐	No ☐	Year _____
Have you ever had melanoma?	Yes ☐	No ☐	Year _____
Does melanoma run in your family?	Yes ☐	No ☐	Year _____
Are you currently pregnant?	Yes ☐	No ☐	
Do you bleed easily?	Yes ☐	No ☐	
Do you have a peacemaker?	Yes ☐	No ☐	Year _____
Do you have any artificial joint?	Yes ☐	No ☐	Year _____
Do you have any artificial heart valves?	Yes ☐	No ☐	Year _____
Do you require antibiotics prior to procedures?	Yes ☐	No ☐	Why _____
Do you form keloids (puffy scars)?	Yes ☐	No ☐	
Social History:			
Do you smoke?	Yes ☐	No ☐	
Do you consume alcohol?	Yes ☐	No ☐	
Do you use IV drugs?	Yes ☐	No ☐	
Current or Past Problems:			
Fever	Yes ☐	No ☐	
Weight gain or loss	Yes ☐	No ☐	
Fatigue	Yes ☐	No ☐	
Depression/ anxiety	Yes ☐	No ☐	
Bleeding / blood disorders	Yes ☐	No ☐	
Anemia/ easy bruising or bleeding	Yes ☐	No ☐	
Heart Disease	Yes ☐	No ☐	
Chest pain/ heart attack	Yes ☐	No ☐	
Heart murmur/ irregular heart beat	Yes ☐	No ☐	
High blood pressure	Yes ☐	No ☐	
Blood clots	Yes ☐	No ☐	
Kidney disease	Yes ☐	No ☐	
Blood in urine	Yes ☐	No ☐	
Increased/ decreased frequency of urination	Yes ☐	No ☐	
Liver disease	Yes ☐	No ☐	
Yellow eyes/ hepatitis	Yes ☐	No ☐	
Lung disease	Yes ☐	No ☐	
Cough/ shortness of breath	Yes ☐	No ☐	
Asthma/ wheezing	Yes ☐	No ☐	
Bronchitis/ emphysema	Yes ☐	No ☐	
Endocrine disorders	Yes ☐	No ☐	
Diabetes/ thyroid disease	Yes ☐	No ☐	
Arthritis/joint pain/ lupus/ artificial joints	Yes ☐	No ☐	
Visio changes/ double vision	Yes ☐	No ☐	
Neurological disease/ Stroke	Yes ☐	No ☐	
Seizures/ headache/ muscle weakness	Yes ☐	No ☐	
Gastrointestinal disease	Yes ☐	No ☐	
Diarrhea/ nausea/vomiting / blood in stool	Yes ☐	No ☐	
HIV/ tuberculosis exposure	Yes ☐	No ☐	
Swollen lymph nodes	Yes ☐	No ☐	
Yeast infections with antibiotics	Yes ☐	No ☐	

_____ _____

Patient Signature Date