AESTHETIC DERMATOLOGY, P.A.
DAVID ALLYN, M.D.

☐ New History ☐ Update ☐ Pre-Op Evaluation Date:_____

Name:_____

How did you hear about our office?_____ Who is your personal physician?_____

Please list all your medications _____

	Yes	No	Not Sure	Family History		Yes	No	Not Sure	Family History		Yes	No	Not Sure	Family History
AIDS					Gastrointestinal					Polio				
Anemia					Gout					Prone To Infection				
Arthritis/Bursitis					Hardening of Artery					Recent Childbirth				
Artif. Heart Valves					Heart Attack					Rheumatic Fever				
Asthma/Hay Fever					Heart Trouble					Shortness of Breath				
Bleeding Problems					Hepatitis					Sickle Cell/Trait				
Blood Disease					Herpes					Spleenectomy				
Bone/Muscle Prob.					High Blood Press.					Stomach Ulcers				
Cancer					HIV					Stroke				
Circulation Problem					Hives					Tuberculosis				
Diabetes					Joint Replacement					Varicose Veins				
Eczema					Kidney/Urinary					Take Aspirin				
Emphysema					Liver Disease					Take Hormone				
Epilepsy/Convulsion					Lung Disease					Use Alcohol				
Eye/Ear Problems					Neurologic Problem					Use Laxative				
Fainting Spells					Palpatations					Use Tobacco				

Please list any previous surgery or recent hospitalization_____

Do you have a pacemaker, artificial valve, prosthetic device, artificial joint, or other surgical implant (circle)

Do you have any physical limitations?_____

Please list and previous anesthesia: ☐ General ☐ Local ☐ Other:_____

Please list any usual reactions to anesthesia_____

Please list all your allergies/sensitivities (known or suspected)_____

Occupation/Hobbies/Activities_____

Marital Status: M S D W Other_____Type of Residence_____

When and where on your body did your problem/condition begin? _____

_____

How and where has it spread?_____

_____

What have you used to treat this? (Prescription and non-prescription items)_____

_____

What do you think may be responsible for your problem/condition?_____

Do you know anyone with a similar problem/condition?_____

Family history of skin disease and significant medical problems_____

_____

Do you get a lot of sun exposure?_____Have you ever had a severe sunburn?_____

Do you use a tanning booth?_____Do you use sunscreen?_____

Have you ever visited a dermatologist? ☐ Yes ☐ No When?_____Why?_____

Have you ever been treated for skin cancer before? ☐ Yes ☐ No When?_____

Reason for visit today_____

Physician's Signature_____