

NALINI G. PRASAD, M.D.

MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

Have you ever had the following:

- | | |
|--|--|
| <input type="checkbox"/> Rosacea | <input type="checkbox"/> Keloid Scar Formation |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Sun Sensitivity |
| <input type="checkbox"/> Cold Sores | |
| <input type="checkbox"/> Allergies (please list): _____ | |
| <input type="checkbox"/> Past Medical Illness (please list): _____ | |
| <input type="checkbox"/> Past Surgeries (please list): _____ | |

Medications/Medical Treatment:

- | | | |
|--|------------------------------|-----------------------------|
| Are you currently taking birth control pills? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you currently pregnant or breast feeding? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you planning on getting pregnant in the near future? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever taken Accutane? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you use any Acne Medication? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If Yes, please list: _____

Other Prescription Medications (including herbal): _____

Over the Counter Medications (including herbal): _____

Are you presently under a physician's care for any condition? If so, please describe:

Lifestyle Information:

- | | | |
|----------------------------|------------------------------|-----------------------------|
| Do you consume alcohol? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you smoke? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you exercise regularly? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you use tanning booths? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Describe your history of sun exposure: _____

Skin Type (Check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Sunburn easily | <input type="checkbox"/> Sunburn, then tan |
| <input type="checkbox"/> Usually tan | <input type="checkbox"/> Always tan |
| <input type="checkbox"/> Sensitive | <input type="checkbox"/> Oily |
| <input type="checkbox"/> Dry | <input type="checkbox"/> Normal |

Cosmetic History (Check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Facial surgery | <input type="checkbox"/> Filler injections |
| <input type="checkbox"/> Botox injections | <input type="checkbox"/> Facial peels |
| <input type="checkbox"/> Laser Treatments (please list): _____ | |

Additional Comments: _____
