

*Skin Laser & Surgery Specialists
of New York and New Jersey*

Patient Name: _____ Age _____ Date: _____

Reason for today's visit: _____

Allergies to Medication: _____

Current Medications (Prescription, Over the Counter, vitamins, herbal supplements): _____

Please CIRCLE ALL answers and explain:

Patient/Family/Social History

Occupation: _____

Do you live alone? YES NO

Do you faint easily? YES NO

Are you pregnant? YES NO

Trying to become pregnant? YES NO

Nursing? YES NO

Do you bruise easily? YES NO

Do you take aspirin or blood thinners? YES NO

Have you ever had a reaction to local anesthetics? YES NO

Do you take antibiotics before dental work? YES NO

Do you have trouble healing? YES NO

Do you develop Keloids? YES NO

Have you had skin reactions to: Medications YES NO

Food YES NO

Environment YES NO

Bandages YES NO

Do you smoke? YES NO Amount: _____

Drink alcohol? YES NO Frequency: _____

Recreational drugs? YES NO Type: _____

Past/present tanning bed use? YES NO Explain: _____

Have you had Skin Cancer? YES NO Type: _____

Other Cancer? YES NO Explain: _____

Family History of Melanoma? YES NO Explain: _____

Review of Systems

Skin Problems: *NONE* Eczema / Psoriasis / Vitiligo / Hair or Nail Changes / Sweating Problems
Other: _____

Cardiac Disorders: *NONE* High B/P / MVP / other: _____

Vascular Problems: *NONE* Edema / Varicose Veins / Bleeding Disorders Other: _____

Lung Disease: *NONE* Asthma / Emphysema / Tuberculosis / Other: _____

Neurological Disorders: *NONE* Headaches / Seizures / Other: _____

Eye, Ear, Nose, Throat Problems: *NONE* / Other: _____

GI/GU - Stomach, Intestines, Kidneys: *NONE* / Other: _____

Musculoskeletal, Artificial Joints, Arthritis: *NONE* / Other: _____

Thyroid disease, Diabetes, Lupus, Auto Immune; *NONE* / Other: _____

Psychological Disorders: *NONE* / Other: _____

HIV, AIDS, Hepatitis, Communicable Diseases: *NONE* / Other: _____

Have you been diagnosed with MRSA: YES NO

Other Important History: _____

Generally Healthy: YES NO

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

Completed by: Patient / Parent / Guardian

-----*To be filled out by office staff only*-----

Past/ Family/ Social History/ System Review Checked by MD: YES NO

Fitzpatrick Skin Type: I II III IV V VI

General Appearance: Clean / Well Nourished / Other: _____

Mood: Pleasant / Anxious / Confused / Other: _____

Does patient need refill RX? YES NO

MA/Nursing NOTES (including location, duration, symptoms, other):

MA/Nurse signature: _____ Date _____