DERMA
MEDICAL SPA

Past Medical History

Print Name: _____ Today's Date: _____

Preferred Pronouns: _____ Date of birth: _____

Phone Number: _____ Email: _____

Address: Street: _____ Apt/Bld # _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us? Facebook ☐ Instagram ☐ Twitter ☐ Google ☐

Referred by: _____

Have you ever had any of the following? (Please check all that apply)

☐ Heart disease ☐ Anemia ☐ Hypertension ☐ Diabetes (Type I or II) ☐ Polycystic Ovarian Disease ☐ Other clotting disorder ☐ COPD ☐ Seizures ☐ HIV/AIDS ☐ Hepatitis C ☐ Lupus ☐ Thyroid Disorder	☐ Rosacea ☐ Eczema ☐ Cystic acne ☐ Herpes I or II ☐ Hormone disorder (please specify): _____ ☐ Cancer (please specify): _____ ☐ Chronic headaches/migraines ☐ Cerebral Palsy ☐ Lou Gehrig's Disease ☐ Asthma	☐ Multiple sclerosis ☐ Autoimmune Disorder (please specify): _____ ☐ Other neurological condition (please specify): _____ Other: _____ _____ _____ _____

Please list any prior surgeries and an approximate date of completion, including all cosmetic procedures:

☐ Appendix _____ ☐ Gallbladder _____ ☐ Heart _____ ☐ Joint replacements _____	☐ Pacemaker _____ ☐ Brain _____ ☐ C-section _____ ☐ Hysterectomy _____	☐ Metal-rods _____ ☐ ANY Other implants: _____	Other: _____ _____ _____ _____ _____

Allergies:

_____

_____

Please list all medications and their dosages:

MEDICATION NAME	DOSAGE/FREQUENCY

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Within the last 2 weeks, have you had any of the following symptoms? (Please check all that apply)

GENERAL	EYES	RESPIRATORY/CHEST	GASTROINTESTINAL
☐ Fevers ☐ Fatigue ☐ Weight loss ☐ Weight gain ☐ Generalized weakness ☐ Excessive sweating ☐ Other: _____	☐ Blurry vision ☐ Vision loss ☐ Other: _____ **HEMATOLOGIC** ☐ Easy bleeding or bruising ☐ Diagnosed blood clot ☐ Other: _____	☐ Cough ☐ Shortness of breath ☐ Painful breathing ☐ Chest pain ☐ Palpitations ☐ Other: _____ _____	☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Abdominal pain ☐ Other: _____ _____

NEUROLOGICAL	SKIN	OTHER
☐ Localized weakness ☐ Speech changes ☐ Headaches ☐ Dizziness ☐ Numbness ☐ Tingling ☐ Seizures ☐ Other: _____	☐ Rash ☐ Abnormal lumps ☐ Dryness ☐ Redness ☐ Blisters ☐ Burns ☐ Other: _____	Please list any other symptoms you've experienced not listed on this page: _____ _____ _____ _____ _____

Do you have any *metal* implants? ☐ YES ☐ NO If yes, where?: _____
Are you currently or trying to get pregnant: ☐ YES ☐ NO Lactating/ breast feeding? ☐ YES ☐ NO
Do you smoke? ☐ YES ☐ NO If yes, how many packs per day? _____
Have you ever taken Accutane? ☐ YES ☐ NO If yes, when was the last dose? _____

Family History

Please check all that apply:

Relative	Heart Disease	Diabetes	Stroke	Anemia	Thyroid Disorder	Cancer	Other (specify):
Mother							
Father							
Sibling							
Sibling							
Sibling							
Sibling							

****FOR OFFICE USE ONLY****

Notes/Changes	Date	Reviewed by:	Initials