

COSMETIC SURGERY & DERMATOLOGY OF ISSAQUAH, INC.

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PATIENT HISTORY

PLEASE COMPLETE ALL INFORMATION

Name: _____ Date: _____

Primary Physician: _____ Date of Birth: _____

Referring Physician: _____

What problem brings you to our office today?

Have you had any previous therapy for this problem? Yes No If yes, please describe.

List any medications you are currently taking.

Do you have any other health problems? Yes No If yes, please list.

Do you have any allergies or sensitivities to medications or foods? Yes No If yes, please list.

Does your religion restrict blood transfusions in emergency situations? Yes No

Do you have Advance Directives? Yes No

Please check the appropriate boxes. Do you have any history of:

- | | | | |
|--------------------------------|--|------------------------|--|
| 1. History of cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. Biopsies or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Family history of cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. Severe sunburn | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. Scar formation | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Positive AIDS antibody test | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Changing moles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Blood Transfusions | <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you checked "Yes" to any of the above questions, please describe including dates (use back if necessary).

