Patients Name: **Address:** **Date of Birth** **Date**

PLEASE READ CAREFULLY AND COMPLETE THE MEDICAL HISTORY FORM

This information is confidential and will be used by Dr Patel to make sure you get proper care.

Reason for consultation:
Expectations:

A. Medical History:

1. **PLEASE READ CAREFULLY**. If YOU have problems with any of these? **Check all that apply.**

A. ❑ **Heart disease**
B. ❑ High blood pressure
C. ❑ Stroke
D. ❑ **Diabetes**
E. ❑ High cholesterol
F. ❑ Blood disorders
G. ❑ Asthma
H. ❑ Blood clot in legs/lungs
I. ❑ **Bleed/bruise easily**
J. ❑ Anemia
K. ❑ **Muscle disease**
L. ❑ Kidney/bladder problems
M. ❑ Seizures or epilepsy
N. ❑ Depression
O. ❑ **Eaton Lambert Syndrome**
P. ❑ Swallowing disordes
Q. ❑ Severe headaches or migraines
R. ❑ Liver problems or hepatitis
S. ❑ **History of keloids**
T. ❑ **Skin disorders**
U. ❑ **Cancer**
Type:_______________
V. ❑ Thyroid disease

2. ❑ Yes ❑ No Have you had **botulinum or dermal filler** treatment previously?
If yes, when and area of treatment? ____
3. ❑ Yes ❑ No Have you **had plastic or cosmetic surgery** previously?
4. ❑ Yes ❑ No Have you ever had **laser / IPL treatment** in the past?
If yes, when? ____________________________
5.. ❑ Yes ❑ No Have you ever had an **HIV test**?
If yes, when was your last one? _____________ Was it: ❑ Positive ❑ Negative?
6. ❑ Yes ❑ No ***Symptoms that may indicate skin cancer include any mole or lesion that***:

❑ **Yes** ❑ **No** **1. Are there lesions over 6mm in diameter**
❑ **Yes** ❑ **No** **2. Changes shape - look for an irregular edge**
❑ **Yes** ❑ **No** **3. Changes colour**
❑ **Yes** ❑ **No** **4. Itchy or painful bleeds or is crusty**
❑ **Yes** ❑ **No** **5. Lesion that is inflamed**

7. ❑ Yes ❑ No Have you any **know allergies**?
8. ❑ Yes ❑ No Do you take any over the **counter medicines, prescription medicines, vitamins, supplements, or home remedies**?

9 ❑ Yes ❑ No Are you **pregnant**?
10. ❑ Yes ❑ No Are you currently **breastfeeding**?

11. How many glasses of an alcoholic beverage do you have per week? ________ ❑ None
12. ❑ Yes ❑ No Do you smoke cigarettes?

13. ❑ Yes ❑ No Is there **anything else** that you would like to discuss with your clinician?

Patients Signature/Date **Physicians Signature/Date**

14. ❑ Yes ❑ No **Are you satisfied with your consultation?**

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