Today's Date:_____

DERMA HEALTH
Laser & Skin Care Clinic

Client History

Name: _____ Date of Birth: _____Age: _____

Address: _____

City State Zip

Cell Phone:_____ Home Phone: _____Work Phone: _____

Email Address: _____ ☐ Female ☐ Male

Emergency Contact: _____ Phone Number: _____

How did you hear about us? _____ Occupation_____

Marital Status _____ Height _____ Weight _____

SURGICAL HISTORY

List surgical procedures including plastic surgery.

_____

_____

_____

OTHER SERIOUS ILLNESS/OPERATIONS

_____

_____

_____

Date of last chest x-ray _____ Date of last EKG _____

MEDICATION

Name	Dosage	**Frequency**

MEDICAL HISTORY

Condition	Self	Family	Clarification
Heart disease disorder	□	□	
Gall bladder disease	□	□	
Headaches	□	□	
Uterine Cancer	□	□	
Osteoporosis	□	□	
High blood pressure	□	□	
Diabetes	□	□	
Asthma	□	□	
Liver Disease	□	□	
Ovarian Cancer	□	□	
Stroke	□	□	
Kidney disease	□	□	
Fibromyalgia	□	□	
Mental disorder	□	□	
Cervical Cancer	□	□	
Varicose veins	□	□	
Seizures	□	□	
Arthritis	□	□	
Thyroid disorder	□	□	
HIV/Aid	□	□	
Prostate Cancer	□	□	
Clotting	□	□	
Colitis	□	□	
Breast Cancer	□	□	

HORMONE AND VITAMIN SUPPLEMENTATION TAKEN

	Supplement	**Total daily dose**		**Supplement**	**Total daily dose**
□	Androstenedione		□	Arimidex	
□	DHEA		□	Estrace	
□	Estradiol		□	Estriol	
□	Estrone		□	Growth Hormone	
□	Human Growth Hormone		□	Melatonin	
□	Pregnenolone		□	Premarin	

□	Progesterone		□	Provera	
□	Tamoxifen		□	Testosterone	
□	Thyroid		□	Vitamin A	
□	Vitamin B3		□	Vitamin B6	
□	Vitamin B12		□	Vitamin C	
□	Vitamin D		□	Vitamin E	
□	Beta Carotene		□	Calcium	
□	Co Q10		□	Chromium	
□	Digestive Enzyme		□	Folic Acid	
□	Iron		□	Magnesium	
□	Selenium		□	Zinc	
□	Probiotic				

SOCIAL

	Yes	No	Amount
Alcohol use	□	□	
Coffee	□	□	
Soft drink	□	□	
Tea	□	□	
High sugar food	□	□	
Chewing tobacco	□	□	
Cigarettes	□	□	
Excessive stress	□	□	

REVIEW OF SYSTEMS

Head			
□	Headaches	□	Blurred vision
□	Cloudy vision		
Hair			
□	Hair loss	□	Dry hair
□	Clumps of hair coming out		
Cardiovascular			
□	Water retention	□	Cannot tolerate much exercise
□	Difficult breathing	□	Chest pain while walking
□	Heaviness in legs	□	Calf muscle cramp often
□	Heart pounds easily	□	Palpitations

□	High blood pressure	□	Low blood pressure
Respiratory			
□	Shortness of breath	□	Chronic lung congestion
□	Wheezes	□	Cough
□	Acute congestion	□	
Gastrointestinal			
□	Constipation	□	Diarrhea
□	Heart burn	□	Abdominal pain
□	Certain foods cause ill feeling	□	Blood in stool
□	Epigastric pain	□	Hernia
Urinary			
□	Frequent Urination	□	Burning with urination
□	Incontinent issues		
Musculoskeletal			
□	Change in muscle mass	□	Joint pain
□	Limitation in motion		
Dermatological			
□	Dry skin	□	Oily skin
□	Acne		
Metabolic			
□	Difficulty gaining weight	□	Difficulty losing weight
□	Sensitivity to cold	□	Wake up craving sweets
□	Fatigue	□	Feel faint
□	Night sweats	□	Increased thirst
□	Craves sweets	□	Weight loss more than 10 lbs in 6 months
□	Weight gain more than 10 lbs in 6 months		
Psychological			
□	Rapid mood swings	□	Moodiness/ change in mood
□	Depression	□	Lack of self-esteem
□	Anxiety	□	Difficulty concentrating
□	Short attention span	□	Forgetfulness
Sleep			
□	Difficulty going to sleep	□	Difficulty staying asleep
□	Wake up frequently		Hours of sleep per night: _____

FEMALES ONLY

□	Bloating and swelling	□	Breast tenderness
□	Miscarriage	□	Vaginal discharge
□	Underactive sex drive	□	Pelvic soreness
□	Menstrual pain	□	Insomnia
□	Vaginal bumps/sores	□	Premenstrual chest discomfort
□	Hot flashes	□	Night sweats
□	Vaginal dryness	□	Infertility
□	Heavy menstrual bleeding	□	Ovarian cysts
□	Breast lump	□	Irregular period

Date of last menstrual cycle: _____ Date of last pap smear/pelvic exam: _____

Date of last mammogram: _____ Sexually transmitted diseases: _____

Form of birth control: _____

MALES ONLY

□	Pain with ejaculation	□	Difficulty maintaining erection
□	Sexual drive underactive	□	Premature ejaculation
□	Pain in genital area	□	Infertility
□	Low sperm count	□	Discharge from penis
□	Rash on penis	□	Swelling in groin
□	Loss of urine control	□	Frequent urination at night

Date of your last prostate exam: _____

Do you use any medications for sexual dysfunction? □ Yes □ No

If so, please list: _____