

- 20. Do you have a history of the following?
 - Heart Disease
 - High Blood Pressure
 - Cold sores
 - Easy Bruising
 - Previous Skin Injuries
 - Diabetes
 - Leg Clots (DVT)
 - Bleeding Disorders
 - Dark spots after pregnancy (melasma)
 - Skin Cancers / suspicious moles
- 21. Do you have any allergies to oral or topical medications? Yes No
If yes, which ones? _____
- 22. Do you have any allergic reactions to topical or local anesthesia? Yes No
If yes, which one(s)? _____
- 23. Do you take or have taken any of the following medications?
 - Aspirin
 - Hormones / Birth Control
 - Thyroid medications
 - Sedatives / Tranquilizers
 - Antibiotics
 - Accutane
 - Anti-coagulants (blood thinners/ Coumadin)
 - Appetite Suppressants (diet pills)
 - Insulin
 - Steroids
 - Herbal preparations (ex. St. John's Wort)
 - Retin-A/Retinol

Please elaborate: _____

- 24. What is your daily consumption of alcohol? _____
- 25. What is your daily consumption of tobacco? _____
- 26. Do you wear contact lenses? Yes No
- 27. Do you tan under the sun or in a tanning booth? Yes No
- 28. Do you use sunscreen or sun block on a daily basis? Yes No
- 29. Do you use chemical sun tanning lotions? Yes No
- 30. Are you planning a holiday in the sun? Yes No
- 31. Do you live in an urban environment? Yes No
- 32. Have you had dental work in the last 6 months? Yes No
- 33. Have you had any major illness in the last 6 months? Yes No
- 34. What is your average daily water intake? (glasses per day) _____

35. What types of foods do you tend to eat regularly? _____

I certify that the answers I gave are true to the best of my knowledge.

Patient Signature

Date