

DULLES COSMETIC SURGERY & SKIN CARE CENTER

MEDICAL HISTORY

Patients Name _____ Date: _____

Please list below any medications you presently take:

Do you take the following drugs and if so how frequently?

Aspirin _____ Anticoagulants _____
(This does not include Motrin, Advil, Tylenol, etc.)

Do you have any drug allergies? Yes _____ No _____
List Allergies

Please list any major operations or medical problems: _____ Date: _____

Do you presently have or have you had any of the following in the past 5 years:
(Please Check off)

Heart Attack _____ High Blood Pressure _____

Asthma _____ Angina _____

Irregular Heart Beat _____ Thyroid Problems _____

Stroke _____ Diabetes _____

Cancer _____ Blood Clots _____

Pulmonary Embolus _____ Epilepsy _____

Drug Dependency _____ Alcoholism _____

Photosensitivity _____ Psoriasis _____

Cold Sores _____ Herpes _____

Do you live alone ? _____ Are you a smoker? _____ If so, how much _____

Is it possible that you are pregnant? _____

If you are considering laser hair removal, have you:

- 1) Have you taken accutane in the past year? _____
- 2) Have you had electrolysis or laser treatment to this area before? _____

Signature of Patient

Date

Patients who do not cancel their scheduled appointments 24 hours prior to appointment, or who do not show up at all for their appointments, will be charged \$100.00