UNIVERSITY DERMATOLOGY
Cosmetic & Surgery Center

Name _____ Age _____

Occupation _____ Date _____

What skin care products, sunscreens, cosmetics, and soaps do you use regularly?_____

_____

What medications are you now taking? Include dose and frequency. _____

_____

_____

	CIRCLE ONE	IF YES, EXPLAIN
Do you have any allergies to medications?	No / Yes	_____
Any previous skin cancer or other cancers?	No / Yes	_____
Have you had any blistering sunburns?	No / Yes	_____
Have you or a family member had melanoma?	No / Yes	_____
Do you have any sinus, hay fever or asthma?	No / Yes	_____
Any trouble with healing? Keloid scars?	No / Yes	_____
Have you ever had liver problems or hepatitis?	No / Yes	_____
Do you have high blood pressure?	No / Yes	_____
Do you have heart problems? Heart attacks?	No / Yes	_____
Do you have any lung or breathing problems?	No / Yes	_____
Do you have any history of tuberculosis?	No / Yes	_____
Do you have fainting spells? Any seizures?	No / Yes	_____
Do you have diabetes? Low blood sugar?	No / Yes	_____
Have you ever been hospitalized?	No / Yes	_____
Have you ever had any cosmetic surgery?	No / Yes	_____
Have you ever had other surgery?	No / Yes	_____
Do you have any chronic medical problems?	No / Yes	_____

Women - Menstrual History: Are you now having regular periods? If not, please explain. _____

_____

Do you take Birth Control Pills? No / Yes If yes, what brand? _____ How long?_____

CONSENT FOR TREATMENT

I hereby give my consent for medical examination and treatment. I consent to routine dermatologic procedures such as skin biopsy, treatment with liquid nitrogen, or the removal of minor skin lesions. These procedures will be explained in detail before treatment.

Date _____ Signed _____