FORT WAYNE DERMATOLOGY CONSULTANTS INC | Fort Wayne Plastic Surgery & Aesthetics

Medical History Form

Last Name: _____First Name: _____ Middle: _____

Date:_____ MR:_____ Birth Date: _____Age: _____

Referring Doctor: _____Primary Care Physician:_____

Reason for today's visit	Location on body	How long has it been going on	Prior Treatments
1.			
2.			
3.			

Personal History

Diabetes	Yes	No
Eczema	Yes	No
Keloid Tendency	Yes	No
Positive TB	Yes	No
Asthma/Seasonal Allergies	Yes	No
Pregnant/Nursing	Yes	No
HIV Positive	Yes	No
Other:		

Family History

Eczema	Yes	No
Psoriasis	Yes	No
Melanoma	Yes	No
Asthma/Seasonal Allergies	Yes	No
Other:		

Do you have medical allergies? Yes No

List Allergies: _____

Medications:	Additional medications:

Are you interested in learning more about:

☐ Skin care ☐ Coolsculpting/Fat reduction ☐ Hair removal ☐ Anti-aging services

Do you have unwanted:

☐ Wrinkles ☐ Brown spots ☐ Acne