OLYMPIC DERMATOLOGY
Medical & Cosmetic Excellence

Date_____
Patient ID_____
Staff _____

Patient Name _____ **Date of Birth** _____

What is your primary reason for today's visit? _____

_____

How did you hear about us? _____

Patient Past Medical History (Please check all that apply)

- ☐ NONE
- ☐ Accutane
- ☐ Asthma/Hay Fever
- ☐ Blood clots
- ☐ Blood borne diseases _____
- ☐ Cancer _____
- ☐ Canker sores, herpes, cold sores
- ☐ Currently pregnant or nursing
- ☐ Dermal filler treatment within the last 30 days
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Eczema
- ☐ Have a pacemaker? Is it a defibrillator? _____
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hives
- ☐ Keloid scarring
- ☐ Malignant melanoma
- ☐ Mental illness
- ☐ Metal Implants
- ☐ Polycystic ovarian syndrome
- ☐ Poor healing
- ☐ Psoriasis
- ☐ Regularly take Aspirin, Advil, Aleve, or Coumadin
- ☐ Significant weight change within last 12 months
- ☐ Skin cancer
- ☐ Skin disease _____
- ☐ STD's _____
- ☐ Stroke
- ☐ Take antibiotics before dental or surgical procedures
- ☐ Thyroid disorder
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ X-ray therapy
- ☐ Other _____

Family Medical History (Please check all that apply) Please specify which family member

- ☐ NONE
- ☐ Autoimmune disorders _____
- ☐ Bleeding disorders _____
- ☐ Eczema _____
- ☐ Skin disease_____
- ☐ Keloid scarring _____
- ☐ Malignant melanoma_____
- ☐ Psoriasis_____
- ☐ Skin cancer_____
- ☐ Other _____

Past Surgeries/Hospitalizations (If none, please write none)

1. _____
2. _____
3. _____
4. _____

Allergies and Reaction (If none, please write none)

1. _____
2. _____
3. _____
4. _____

Please continue to back side. Thank you!

Medications and Dosages (If none, please write none)

1. _____ 3. _____

2. _____ 4. _____

Social History (Please check all that apply)

ALCOHOL USE

- ☐ No alcohol use
- ☐ 1-3 drinks/day (in last 12 months
- ☐ 4 drinks/day (in last 12 months)
- ☐ 5 + drinks/day (in last 12 months)

TOBACCO USE: ☐ No tobacco use ☐ Current tobacco user

FLU SHOT (in last 12 months?): ☐ Yes ☐ No

PNEUMONIA VACCINE: ☐ Yes ☐ No **COLONOSCOPY (in last 9 years):** ☐ Yes ☐ No

MAMMOGRAM (in last 2 years)? ☐ Yes ☐ No **HEIGHT (INCHES):** _____ **WEIGHT (LBS):** _____

Skin Care

1. What is your current skin care routine? _____
2. Do you have any unwanted hair? Where? _____
3. Do you pluck, wax or shave unwanted hair? _____
4. Do you use makeup products? Which ones? _____
5. Do you currently use a skin bleaching product? _____
6. Which skin type do you feel you have? (Dry, oily, etc.) _____
7. Are you sensitive to sunscreen? If yes, what type? _____
8. Are you interested in scheduling an additional complimentary consult to discuss any other topics listed below?
   - ☐ Skin care advice/products
   - ☐ Sunscreen advice
   - ☐ Botox
   - ☐ Facial rejuvenation
   - ☐ Facial wrinkles
   - ☐ Tattoo removal
   - ☐ Laser resurfacing
   - ☐ Thin lips
   - ☐ Length/fullness of eyelashes
   - ☐ Facial slackness/loss of elasticity
   - ☐ Chemical peels
   - ☐ Mineral based makeup
   - ☐ Liposuction or blepharoplasty
   - ☐ Unwanted fat
   - ☐ Facial redness
   - ☐ Liver spots/age spots
   - ☐ Removing facial veins
   - ☐ Removing leg veins/spider veins
   - ☐ Hair removal
   - ☐ Facial fillers
   - ☐ Skin tightening
9. Have you had any of these treatments before? Which ones? _____

Which pharmacy do you prefer? _____

Pharmacy Street, City