Patient Medical History

Mariano Busso, M.D., P.A.

Dr. mariano BUSSO aesthetic dermatology

Name: _____ Date: _____

IV. Past Medical History

1. Have you ever been hospitalized? Yes No

If yes, specify, hospital, reason and year _____

_____

2. Have you ever had any surgery? Yes No

If yes, what type of surgery and when _____

_____

3. Have you had any problems of the skin, hair or nails? Yes No

If yes, specify, type and treatment _____

_____

4. Have you ever had skin cancer? Yes No

If yes, specify type, location, treatment and year _____

_____

5. Do you have or have had in the past any of the following conditions?

If yes please specify

O Anemia	O Artritis	O Asthma	O Bleeding Disorder
O Bronchitis	O Cancer	O Cataracts	O Chicken Pox
O Diabetes	O Epilepsy	O Glaucoma	O Goiter
O Gout	O Heart Disease	O Hepatitis	O Hernia
O Herpes	O High Blood Pressure	O High Cholesterol	O HIV positive
O Kidney Disease	O Liver Disease	O Measles	O Migraine
O Miscarriage	O Monobucleosis	O Multiple sclerosis	O Mumps
O Pacemaker	O Pneumonia	O Polio	O Prostate problems
O Psychiatric care	O Rheumatic Fever	O Scarler fever	O Stroke
O Thyroid problems	O Ulcer of the stomach	O Vernal disease	

Other (s) _____

6. Please list your current immunizations _____

V. Family History

Mother: living/deceased age _____ illnesses _____

Father: living/deceased age _____ illnesses _____

Number of children: _____ ages _____ illnesses _____

VI. Health Habits

Do you consume any of the following substances: tobacco, caffeine, alcohol, drugs, other Yes No

If yes describe_____

Are you exposed to second hand smoke? Yes No

If yes describe _____

VII. Current Medical History

1. Do you have any allergies (medicines, foods, pollen, etc.) ? Yes No

If yes, list them and briefly describe your reaction (i.e. rash, fever, shortness of breath) _____

_____

2. List of medications you are currently taking (including non-prescription medicines) Yes No

_____

3. List topical (creams, gels, lotions, ointments, makeup, moisturizers, etc.) you are currently applying Yes No

_____

I have disclosed all my medical information _____

Patient Signature **Date**

Mariano Busso, M.D., P.A. _____ Date_____