Dermatology of the Berkshires pc

VICTORIA R. CAVALLI, M.D. BOARD CERTIFIED DERMATOLOGIST

COSMETIC/MEDICAL HISTORY

NAME: _____ DOB: _____ AGE:_____ DATE: _____

Reason for visit: _____

MEDICAL HISTORY:

Are you under the care of a physician at this time? ☐Yes ☐No

Please check any conditions below that you have:

☐ Cardiac problems (pacemaker of defibrillator)
☐ Surgical Implants
☐ Bleeding disorder/bruise easily
☐ Seizures
☐ Rosacea, eczema, psoriasis or skin cancer
☐ Skin disorders or lesions
☐ Hormone imbalance (PCOS,thyroid)
☐ High Blood Pressure
☐ Keloids/Scarring
☐ Impaired healing
☐ Cancer
☐ Arthritis
☐ Cold sores/fever blisters
☐ Immunosuppression
☐ Kidney disease
☐ Diabetes
☐ Clotting disorder/DVTs
☐ Vitiligo
☐ Hepatitis
☐ Collagen-vascular disease (Lupus, RA, Scleroderma)
☐ Other _____

Are you pregnant, nursing or contemplating pregnancy at this time? ☐Yes ☐No

Do you smoke? ☐Yes ☐No If yes, how much? _____

Do you drink alcohol? ☐Yes ☐No If yes, how many drinks/daily/weekly? _____

Do you exercise? ☐Yes ☐No If yes, How? _____

Do you follow a special diet? ☐Yes ☐No What? _____

On average, how much sleep do you get per night? _____

SURGICAL HISTORY:

Please list all surgeries and approximate dates: _____

_____

IPL/LASER HISTORY:

Please list treatments, location and approximate dates: _____

_____

LIPOSUCTION HISTORY:

Please list treatments, location, and approximate dates: _____

_____

LEG VEIN HISTORY:

Please list any vein stripping, sclerotherapy, or laser vein treatments and approximate dates: _____

_____

COSMETIC HISTORY:

Have you had any of the following injections or fillers? Please check all that apply.

☐ Collagen ☐ Restylane/Perlane ☐ Sculptra ☐ Juvederm ☐ Botox ☐ Dysport ☐ Other_____

Date of last treatment: _____

MEDICATIONS:
Please list any prescription drugs, dietary supplements, herbal remedies or other over-the-counter medications that you take: _____

_____

Have you ever had Accutane or gold therapy? ☐Yes ☐No What year? _____

ALLERGIES:
Are you allergic to any medicines, foods or products? ☐Yes ☐No If yes, which ones: _____

_____

Have you ever had an allergic reaction to any of the following? Please check all that apply.
☐ Latex ☐ Lidocaine ☐ Bandaids ☐ Anesthesia ☐ Topical anesthetics ☐ Antibiotic ointments

FAMILY HISTORY:
Do you have family history of skin disorders (such as eczema, psoriasis, skin cancer, keloids/scarring), autoimmune diseases, bleeding disorders, clotting disorders, varicose veins and/or excessive hair? ☐Yes ☐No

_____

SOCIAL HISTORY:
Occupation: _____ Hobbies: _____

SKIN TYPE:
Ancestry: _____
Which of the following best describes your skin reactions when you are in the sun?

☐ Always burns, never tans ☐ Rarely burns, always tans

☐ Always burns, sometimes tans ☐ Sometimes burns, always tans

Are you tan? ☐Yes ☐No Please check: ☐ Sun tan ☐ Tanning bed ☐ Self tanner ☐ Spray tan

Do you plan to go on vacation in the near future? ☐Yes ☐No

Do you wear sunscreen? ☐ Never ☐ Sometimes ☐ Always What SPF? _____
What skin care products do you use (cleanser, moisturizers, retinoids, or other anti-aging cosmeceuticals? _____

_____

Do you have any tattoos or permanent makeup? ☐Yes ☐No Do you have any beauty marks? ☐Yes ☐No

Do you have problems with hypo or hyperpigmentation (lightening or darkening of the skin)? ☐Yes ☐No

How did you hear about this office: ☐ Doctor _____ ☐ Newspaper/magazine

☐ Friend/Family _____ ☐ Berkshire Bride

☐ Website ☐ Other ☐ Phone book

Signature: _____ Date: _____