Medical Update Form

Patient Name: Date:

Preferred Pharmacy_____ City_____ Phone No:_____

Medication:	Dose	Frequency

Primary Care Physician:

Address:

Phone Number:

Allergies:

New Medical Problems:

New Surgical History:

Please circle:

Cold Sores	YES/NO	Pregnant or planning pregnancy	YES/NO
Allergy to adhesives	YES/NO	Rapid heart beat with epinephrine	YES/NO
Allergy to Lidocaine	YES/NO	Allergy to latex	YES/NO
Allergy to topical antibiotics	YES/NO	Premedication prior to procedures	YES/NO
History of MRSA	YES/NO	Artificial Joint	YES/NO
Have you ever fainted	YES/NO	Peanut Allergy	YES/NO
Do you have a Pacemaker	YES/NO		

What is your skin care regimen?

AM PM

Family History:	Mother	Father	Sister	Brother
Melanoma				
Non-Melanoma skin cancer				
Other skin conditions:				
Any cancers? (type)				
Unknown				