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www.novamedgroup.com

Medical History

Patient Name: _____ Date: _____

Contact Number: _____

Reason for today's visit: _____

Are you ALLERGIC to any medications? Yes No If Yes, please list:

MEDICINE	REACTION
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS and SUPPLEMENTS / HERBALS you are currently taking None

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Please list your MEDICAL problems (not skin): _____

Do you or have you ever smoked? Yes No # packs per day _____ # of years _____ date quit _____

Have you ever had a SKIN CANCER? Yes No If Yes, circle type:

MELANOMA / BASAL CELL CARCINOMA / SQUAMOUS CELL CARCINOMA

History of other SKIN PROBLEMS? None List: _____

Is there a FAMILY HISTORY of MELANOMA? Yes No Who? _____

Is there a FAMILY HISTORY of NON-MELANOMA SKIN CANCER? Yes No

Do you have a history of a bleeding disorder? Yes No

Occupation: _____

Have you had any Fevers, Chills, Sweats or Malaise? Yes No