SATO GENERAL & COSMETIC DERMATOLOGY, LLC

Patient Health History as of ___________________ (enter today's date)

(Please Print Legibly & Fill In All Fields)

PATIENT'S NAME ____ Birthdate ______________

First Middle Last

Reason for visit: ____ Gender ◯ Male ◯ Female

How long has this problem been ongoing for? ______________________________

Prior Treatments: ____

SKIN HISTORY

◯ Abnormal Moles
◯ Acne
◯ Actinic Keratosis
◯ Blistering sunburns
◯ Dry skin
◯ Eczema
◯ Flaking/itching scalp
◯ Hay fever/allergies
◯ Psoriasis
◯ Rosacea
◯ Urticaria/hives
◯ Use of tanning salons

	Past Skin History	Year	Details
◯	Basal Cell Carcinoma		
◯	Squamous cell cancer		
◯	Melanoma		
◯	Other		

Do you wear suncreen? ◯ Yes ◯ No If yes, what brand & SPF? ______________________________

Has any one in your family had skin cancer? If yes, who and what type? ______________________________

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PAST MEDICAL HISTORY

◯ No other medical problems
◯ Arthritis
◯ Artificial Joints
◯ Asthma
◯ Atrial fibrillation
◯ Bone marrow transplant
◯ Cancer-breast
◯ Cancer-colon
◯ Cancer-lung
◯ Cancer-prostate
◯ COPD
◯ Coronary artery disease
◯ Dementia
◯ Depression
◯ Diabetes
◯ End stage renal disease
◯ Hepatitis
◯ Hypertension
◯ HIV/AIDS
◯ Hypercholesterolemia
◯ Leukemia
◯ Lymphoma
◯ Stroke
◯ Thyroid Disease

Other ____

Have you had any surgeries? If so, what and when? ______________________________

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PAST MEDICAL HISTORY (CON'T)

Do you have any allergies? ◯ Yes ◯ No *If yes, to what?* ______________________

Do you have a reaction to adhesive? (Band-Aids) ◯ Yes ◯ No

Do you have an allergic reaction to topical antibiotic ointments? ◯ Yes ◯ No

Do you have a pacemaker/defibrillator? ◯ Yes ◯ No

Do you take blood thinners (aspirin, coumadin/warfarin, plavix/clopidogrel)? ◯ Yes ◯ No

Are you currently taking any medications? ◯ Yes ◯ No

Please list: ______________________

Are you currently taking any vitamins/supplements? ◯ Yes ◯ No

Please list: ______________________

Are you pregnant/planning or breastfeeding? ◯ Yes ◯ No

SOCIAL HISTORY

Smoking: ◯ Non-Smoker ◯ Former ◯ Current

Alcohol: ◯ None ◯ Socially ◯ Daily

Occupation/Workplace: ______________________

REVIEW OF SYSTEMS

Do you have any of the following?

◯ Fever ◯ Cough ◯ Diarrhea

◯ Fatigue ◯ Shortness of breath ◯ Urinary problems

◯ Chest pain ◯ Abdominal pain ◯ Menstrual irregularities

COSMETIC CONCERNS

Are you Interested in services to reduce fine lines, wrinkles, or sunspots? ◯ Yes ◯ No

If yes, would you be interested in: (check all that apply)

◯ Botox ◯ Chemical peels ◯ Other in-office procedures

◯ Filler (Juvederm, Radiesse, Belotero ◯ Spider veins ◯ At home products

Signature ______________________ *Date* ______________