THE
DERMATOLOGY
& COSMETIC
CARE CENTER

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PERSONAL MEDICAL HISTORY

CUTANEOUS VASCULOPROLIFERATIVE LESIONS

NAME:___________________________________
DATE:____________________________________
INSURANCE:______________________________

1. Are you consulting for?
   __ Cosmetic purposes
   __ Medical Purposes
   __ Both

2. Indicate which symptoms you have experienced:
   __ Flushing __ Blushing __ Itching
   __ Stinging __ Burning __ Warmth
   __ Pain __ Aching __ Heat
   __ Other ____

3. In general, are your symptoms:
   __ Intermittent __ Persistent __ Chronic
   __ Daytime __ Evening
   __ Recent onset? ____________months/years

4. Signs you experience:
   __ Rosy cheeks __ Red patches __ Red or blue lines or vessels
   __ Bruising __ Sunburn-like areas __ Knobby bumps on the nose
   __ Whiteheads __ Blackheads __ Cysts or nodules
   __ Scaling areas __ Dilated pores __ Changes in color or size
   __ Bleeding or crusting after minor trauma
   __ Other ____

5. In general, are the above occurrences?
   __ Intermittent __ Persistent __ Chronic
   __ Recent onset? ____________months/years

6. Are your signs or symptoms worsened by?
   __ Sunlight __ Stress __ Exercise
   __ Alcohol __ Menopause __ Menses
   __ Medicines __ Foods
   __ Other ____

7. Present or prior treatment:
   - Creams ____
   - Soaps ____
   - Moisturizers ____
   - Pillls ____

- Make-up or cover-up ______________________________________
- Sunscreens ____
- Sclerotherapy (when & where) ____________________________
- Laser (when & where) ___________________________________

8. As a result of your vascular lesions do you experience?

__ Lessened self-esteem	__ Lessened employability
__ Embarrassment	__ Avoidance of social situations
__ Self-consciousness	__ Discomfort
__ Constant need for make-up or cover-up	

9. Do you have a family history of?

	No	Yes	Family Member
• Vein problems	_____	_____	______________
• Phlebitis (inflammation of a vein)	_____	_____	______________
• Blood clots	_____	_____	______________
• Leg ulcers	_____	_____	______________
• Easy bruising	_____	_____	______________
• Prolonged bleeding	_____	_____	______________
• Fainting or seizures	_____	_____	______________

10. Do you have a personal history of?

a. Medication problems	Allergies	Overreaction	Adverse Reaction
• Penicillin	________	___________	________________
• Mycins	________	___________	________________
• Other antibiotics	________	___________	________________
• Aspirin	________	___________	________________
• Codeine	________	___________	________________
• Morphine	________	___________	________________
• Tetanus	________	___________	________________
• Antitoxin	________	___________	________________
• Topical anesthetics (Lidocaine, Tetracaine, Xylocaine)	________	___________	________________

	No	Yes
b. Allergies to cosmetics	_____	_____
c. Proneness to syncope or fainting spells	_____	_____
d. Proneness to bruising	_____	_____
e. Non-aesthetic scars and difficult skin healing	_____	_____
f. Sensitivity to pain	_____	_____

11. Have you suffered from one of the following?	No	Yes	Date
• Heart disease	_____	_____	___________
• Anemia	_____	_____	___________
• Jaundice	_____	_____	___________
• Hepatitis	_____	_____	___________
• Epilepsy	_____	_____	___________
• Migraine headaches	_____	_____	___________
• Diabetes	_____	_____	___________
• Skin cancer	_____	_____	___________
• High or low blood pressure	_____	_____	___________
• Nervous breakdown	_____	_____	___________
• Hay fever or asthma	_____	_____	___________
• Hives, eczema	_____	_____	___________
• Frequent infections or boils	_____	_____	___________

12. Have you ever had your veins treated?	No	Yes	Date
Sclerotherapy	____	____	__________
Laser therapy	____	____	__________
Electrocauterization	____	____	__________
Surgery	____	____	__________

13. Are you taking any medication(s)?	No	Yes
Aspirin	____	____
Anticoagulants	____	____
Hormones or contraceptives (birth control pills)	____	____
Chemocautery or any type of tumor	____	____
Thyroid medication	____	____
Cortisone	____	____
Insulin	____	____
Sedatives (sleeping pills)	____	____
Tranquilizers	____	____
Appetite depressants	____	____
Antabuse	____	____
Others	____	____

Specify: ________________________________

	No	Yes
14. Does your work require prolonged exposure to the sun or elements?	____	____
15. Do you smoke? If yes, how many per day? _____	____	____
16. Do you drink? If yes, how many drinks per day? _____	____	____
17. Have you ever had a blood transfusion?	____	____
18. Present illness (if any) Specify: ____ ____	____	____
19. Do you have any idea of your exposure or contamination to the AIDS disease?	____	____

	No	Yes	Date
20. Have you been tested for AIDS? Results: ___________________	____	____	__________
21. Have you ever been tested for Hepatitis? Results: __________________________	____	____	__________
22. Have you ever been vaccinated for Hepatitis?	____	____	__________
23. Have you been immunized against?			
• Small pox	____	____	__________
• Tetanus	____	____	__________
• Polio	____	____	__________

24. Indicate the date of your last: Physical examination ______________________ Laboratory tests __________________

25. Have you had X-Rays of?

	No	Yes	Date
• Chest	____	____	__________
• Stomach	____	____	__________
• Gall Bladder	____	____	__________
• Extremities	____	____	__________
• Back	____	____	__________
• Cancer Therapy	____	____	__________
• Other	____	____	__________

- Specify: _________________________________

26. Systems review:

	No	Yes
• Any eye disease, injury or impaired sight	____	____
• Any ear disease, injury or impaired hearing	____	____
• Any trouble with nose, sinuses, mouth or throat	____	____
• Convulsions	____	____
• Paralysis	____	____
• Dizziness	____	____
• Frequent or severe headache	____	____
• Enlarged glands	____	____
• Enlarged goiter	____	____
• Skin disease	____	____
• Cough, frequent or chronic	____	____
• Chest pain or angina pectoris	____	____
• Spitting up blood	____	____
• Night sweats	____	____
• Shortness of breath	____	____
• Palpation or fluttering heart	____	____
• Liver disease or gall bladder disease	____	____
• Colitis or other blood disease	____	____

27. Please describe in detail any comments or symptoms you are experiencing as a result of your condition. ________

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28. Is there any additional information, which you would consider pertinent? ______________________________

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29. Do you wish to be included in our periodic follow-up assessment recall list? ___________________________

30. Do you wish to receive our newsletters and educational updates? _____________________________________