

Patient Demographic Form

Patient Name:	_	SS#:	DOB:
Address:	_	Mobile Phone:	
City, State Zip	Email:		
Sex: M F			
May we leave messages for you on your mobile phone	? YES	NO	
May we contact you through e-mail?	YES	NO	
Emergency Contact Information			
Name:		Relationship:	
May er discuss your medical records with this person? Y	ES NO	Mobile Phone:	



Medical History Form

			Date:_			
Age: Male: Female:						
How did you hear about our practice?						
Have you had in the past or do you currently have? :						
Pigmentation issues, hyper or hypo pigmentation	Υ	NHeart Di	sease Y	N		
Diabetes	Υ	N	Irregular Pulse		ΥI	N
Gold Therapy	Υ	N	Fainting Spells		ΥI	N
Seizure Disorder (Epilepsy)	Υ	N Asthma			Y N	N
High Blood Pressure	Υ	N	N Keloid Formation		ΥI	N
Polycystic Ovarian Syndrome	Υ	N	Rosacea		ΥI	N
Irregular Menses	Υ	N	Lupus		ΥI	N
Thyroid Disorder	Υ	N	Hepatitis		ΥI	N
History of Herpes Simplex infections/fever blisters	Υ	N	Chemotherapy		ΥI	N
Acne	Υ	N	Skin Cancer		ΥI	N
Are you Photosensitive	Υ	N	Have you ever used Retin-A?		ΥI	N
Have you ever had a chemical peel or microderm?	Υ	N	Have you ever taken Acutane?		ΥI	N
Do you have any Tattoos or permanent makeup?	Υ	NCancer	Υ	N		
Have you ever had any laser treatments?	Υ	N	Other medical issues or illnesses		Υ	N
			Radiation therapy.		ΥI	N
What topical medications or creams are you currently usin	g? Re	etin-A, Others	5?			
What topical medications or creams are you currently usin Are you taking mood altering or anti-depression medication			5?			
	n?	YN				
Are you taking mood altering or anti-depression medication	n? ves, w	YN /hy?	changed the color of you skin? Y N			
Are you taking mood altering or anti-depression medication Are you under the care of a physician?Y NIf y Drug Allergies: (Please list any known drug allergies) : Have you had any recent tanning, sun exposure or used ta	n? ves, w nning	Y N why? creams that Do you scar	changed the color of you skin? Y N easily?YN Do you heal quic			
Are you taking mood altering or anti-depression medication. Are you under the care of a physician?Y N If y Drug Allergies: (Please list any known drug allergies): Have you had any recent tanning, sun exposure or used tallo you use sunscreen?YN What SPF? Have you used any of the following hair removal methods	n? ves, w nning	Y N why? creams that Do you scar	changed the color of you skin? Y N easily?YN Do you heal quic			
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I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the staff at Danvers Family Doctors, P.C. of my current medical or health conditions and to update this history with any changes that my occur. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature: Date:_	
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