

MICHAEL H. COVERMAN, M.D.
(512) 345-9411

JENNIFER JORDAN, MS, PA-C
www.laserskin.com

To help evaluate your past, present and future health concerns please complete the following medical history form:

Name _____ Age _____ Sex: M or F Date: _____

Check all that apply:

A history of: x-ray treatments _____ UV light treatments _____ raised scars _____ Immunosuppression _____

System Review: (Complete or check all that applies to your health and add any important problems)

Medication Allergies: _____

Allergy to: Latex? _____ Lidocaine? _____ Xylocaine? _____

Current Medications (including vitamins/supplements/herbs):

Skin:

_____ abnormal scarring
_____ poor healing
_____ hives/urticaria
_____ unwanted facial hair/
body hair
_____ cold sores/fever
blisters
_____ dry skin/lips/eczema
_____ other _____

Infections:

_____ tuberculosis (Tb)
_____ hepatitis: type _____
_____ HIV/AIDS
_____ venereal disease/
(STDs)
_____ other _____

Psychiatric:

_____ depression
_____ other _____

Musculoskeletal: _____

joint aches

_____ arthritis
_____ artificial joints
_____ lupus
_____ other _____

**Eyes/ Ears/ Nose/
Throat:**

_____ visual problems
_____ glaucoma
_____ hearing aid
_____ sinus problems
_____ other _____

Neurological:

_____ headache
_____ stroke
_____ seizures
_____ other _____

Respiratory:

_____ emphysema
_____ asthma
_____ other _____

Gastrointestinal:

_____ liver damage
_____ colitis
_____ stomach ulcer
_____ other _____

Constitutional:

_____ fever
_____ weight loss
_____ other _____

Hematologic:

_____ anemia
_____ blood clots or

_____ bleeding problems
_____ other _____

Endocrine:

_____ kidney disease
_____ diabetes
_____ thyroid disease
_____ other _____

Cardiovascular:

_____ heart murmur
_____ artificial heart valve
_____ pacemaker
_____ heart attack
_____ mitral valve prolapse
_____ high blood pressure
_____ other _____

Oncology/Cancer:

_____ If yes, what type:

treatment _____

For Females: Are you pregnant? _____ Are you planning to be pregnant any time soon? _____

Please describe your menstrual cycles: _____

PAST HISTORY

Personal history of skin cancer: _____ no _____ yes (and please list) _____

Recent Hospitalizations _____

Any recent surgery _____ Any major surgery _____ Any cosmetic surgery _____

Other important medical history not listed above _____

FAMILY HISTORY

Skin cancer: no _____ yes _____ (and please list) _____

Hair loss _____; psoriasis _____; severe acne _____; asthma _____; environmental allergies _____; eczema _____; high cholesterol _____;

depression _____; keloids/ raised scars _____; thyroid disease _____; other _____

SOCIAL HISTORY

Occupation: _____ Hobbies: _____

Previous sunlight exposure or sunburn: mild _____; moderate _____; extensive _____; tanning bed use: no _____; yes _____

Smoking: no _____ yes _____ former _____; Alcohol: no _____ yes _____ amount _____