RADIANT
DERMATOLOGY & AESTHETICS

Liet N. Le, MD, FAAD
P : 281-973-4159 F : 281-973-2359

Medical History & Medication Form

PATIENT NAME: _____ DOB: _____ DATE: _____

CHIEF COMPLAINT: Please describe the reason for visiting:

_____

_____

How Long: _____ Symptoms: _____ Treatments Tried: _____

MEDICAL HISTORY:

Past Medical History: *Please circle all that apply*

Anxiety	Breast Cancer	Hearing Loss	Lymphoma
Arthritis	Colon Cancer	Hepatitis/Liver Disease	Prostate Cancer
Artificial Joints	COPD	High Blood Pressure	Radiation Treatment
Asthma	Coronary Artery Disease	HIV/AIDS	Seizures
Atrial Fibrillation	Depression	High Cholesterol	Stroke
Bleeding Disorder	Diabetes	Thyroid Disease	NONE
BPH	End Stage Renal Disease	Leukemia	
Bone Marrow Transplant	GERD	Lung Cancer	

Other (Not Listed): _____

Skin Disease History: *Please circle all that apply*

Actinic Keratosis (Precancers)	MOHS Surgery	Contact Dermatitis	Lupus
Basal Cell Carcinoma	Dry Skin (Xerosis)	Poison Ivy	Vitiligo
Squamous Cell Carcinoma	Eczema/Dermatitis	Hives	Rosacea
Melanoma	Asthma	Flaky/Itchy Scalp (Dandruff)	Hair Loss
Dysplatic Nevus (Abnormal Moles)	Hay Fever	Psoriasis	Acne

Do you wear sun screen?	Yes	No	If yes, what SPF? _____
Do you tan in a tanning bed?	Yes	No	If yes, how often? _____
Do you have a **family history** of the following?			
Malignant Melanoma	Yes	No	
Dysplatic Nevi (Atypical Moles)	Yes	No	
Psoriasis	Yes	No	
Lupus	Yes	No	

PREVIOUS SURGERIES: Please list surgery and dates, include any complications with anesthesia

_____

_____

_____

MEDICATIONS: Please include any over the counter medications or supplements you are currently taking

_____

_____

_____

ALLERGIES:

_____

_____

_____

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ADDITIONAL QUESTIONS:

Are you a smoker?	Yes	No	How many years?	# per day?
Do you drink alcohol?	Yes	No	How often?	
Do you use drugs?	Yes	No	Type?	Frequency?
If 65 or older, have you received the pneumonia vaccine?	Yes	No		

What is your preferred language?

ALERTS/CAUTIONS :

Allergy to Adhesive	Yes	No
Allergy to Lidocaine	Yes	No
Allergy to Latex	Yes	No
Have you ever had difficulty stopping bleeding?	Yes	No
Do you require antibiotics prior to a surgical procedure?	Yes	No
Do you have an artificial joint replacement?	Yes	No
Do you have an artificial heart valve?	Yes	No
Do you have a pacemaker?	Yes	No
Do you have a defibrillator?	Yes	No

PREFERRED PHARMACY:

Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: _____ City: _____ State: _____ Zip Code: _____

FEMALE SPECIFC QUESTIONS :

Are you currently pregnant ?	Yes	No
Are you planning on getting pregnant?	Yes	No
Are you breastfeeding?	Yes	No

Print Patient Name : _____ Date : _____

Patient Signature : _____ Date : _____