HEALTH INFORMATION

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Patient's Name: ______________________________ Date of Birth ____________ Today's Date ____________
(Please Print)

Review of Systems: Are you currently experiencing any of the following? (please check Yes or No)

Symptom	Yes	No	Symptom	Yes	No
Fever/Chills			Problem with Healing		
Night Sweats			Problem with Scarring/Keloids		
Unintentional Weight Loss			Rash		
Shortness of Breath			Headaches		
Cough			Seizures		
Chest Pain			Anxiety		
Abdominal Pain			Depression		
Joint Aches			Hay Fever		
Muscle Weakness			Problems with Bleeding		
Thyroid Problems			Immunosuppression		

Other Symptoms: ____

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Alerts: Are you currently experiencing any of the following? (please check Yes or No)

Alert	Yes	No	Alert	Yes	No
Pregnant or Planning a Pregnancy			Defibrillator		
Artificial Heart Valve			Pacemaker		
Artificial joint within the past 2 years			History of MRSA		
Prophylactic Antibiotics			HIV Positive		
Blood Thinners (Aspirin, Coumadin, etc.)			History of Hepatitis B		
Allergy to Lidocaine			History of Hepatitis C		
Rapid Heartbeat with Epinephrine			Allergy to Latex		
Allergy to Topical Antibiotics			Immunosuppression		
Allergy to Adhesive			Fainting with Procedures		
Problem with Bleeding					

Other Symptoms: ____

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Missed appointments without a compelling reason may be charged a no-show fee up to $100 unless 24 hours' advance notice is given.
Visit our website at www.susongderm.com for more information.