



NALINI G. PRASAD, MD

MEDICAL HISTORY FORM

Patient Name: _____

Date: _____

Have you ever had the following:

- Rosacea
- Bleeding Disorder
- Cold Sores
- Allergies (please list): _____
- Past Medical Illness (please list): _____
- Past Surgeries (please list): _____
- Keloid Scar Formation
- Sun Sensitivity

Medications/Medical Treatment:

- Are you currently taking birth control pills? Yes No
- Are you currently pregnant or breast feeding? Yes No
- Are you planning on getting pregnant in the near future? Yes No
- Have you ever taken Accutane? Yes No
- Do you use any Acne Medication? Yes No
- If Yes, please list: _____

Other Prescription Medications (including herbal): _____

Over the Counter Medications (including herbal): _____

Are you presently under a physician's care for any condition? If so, please describe: _____

Lifestyle Information:

- Do you consume alcohol? Yes No
- Do you smoke? Yes No
- Do you exercise regularly? Yes No
- Do you use tanning booths? Yes No

Describe your history of sun exposure: _____

Skin Type (Check all that apply):

- Sunburn easily
- Usually tan
- Sensitive
- Dry
- Sunburn, then tan
- Always tan
- Oily
- Normal

Cosmetic History (Check all that apply):

- Facial surgery
- Botox injections
- Laser Treatments (please list): _____
- Filler injections
- Facial peels

Personal Comments: _____
