

Martha E. Stewart, M.D. L.L.C.
Dermatology Medical History

Patient: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, please list: _____

List all medications you are currently taking (including prescriptions, over-the counter meds, vitamins, and herbals)

Primary Physician _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO	Other Systemic:	YES	NO	Infectious Disease:	YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis: A B or C	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis/other STD's	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Herpes Simplex	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	Antiviral Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Connective Tissue	<input type="checkbox"/>	<input type="checkbox"/>			
			Stomach Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Females:	YES	NO
Cardiovascular:	YES	NO	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, Vomiting,	<input type="checkbox"/>	<input type="checkbox"/>	Could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	diarrhea when taking			Date of last menstrual		
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	antibiotics			cycle _____		
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when	<input type="checkbox"/>	<input type="checkbox"/>	Type of birth control		
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	taking antibiotics			_____		
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>	Previous pregnancies		
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>			
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Past Medical History:		
			Glasses/Contacts	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Skin:	YES	NO	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____		
History of Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____		
If yes, type _____			Type _____			_____		
Family history of skin	<input type="checkbox"/>	<input type="checkbox"/>	Polycystic Ovarian	<input type="checkbox"/>	<input type="checkbox"/>	Past Surgical History:		
Cancer			Disease			_____		
If yes, type _____			Hirsutism/Hypertrichosis	<input type="checkbox"/>	<input type="checkbox"/>	_____		
History of specific skin	<input type="checkbox"/>	<input type="checkbox"/>	Cushing's disease	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Diseases								
Problems with healing	<input type="checkbox"/>	<input type="checkbox"/>	Social History:			Past Family History: please circle		
Excessive scarring/Keloids	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer (Basal Cell, Melanoma,		
Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Squamous Cell), psoriasis, eczema,		
Skin Rashes	<input type="checkbox"/>	<input type="checkbox"/>	If yes, _____ per day			hair loss?		
Reaction to Medications	<input type="checkbox"/>	<input type="checkbox"/>	Do you use IV drugs?	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Reaction to Food	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what? _____			_____		
Reaction to Environment	<input type="checkbox"/>	<input type="checkbox"/>	How often? _____			_____		
Sensitivity to Sunlight	<input type="checkbox"/>	<input type="checkbox"/>						

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Dermatology Medical History continued

Would you be interested in any of the following? (check all that apply.)

- Juvederm / Collagen
- Chemical Peels
- Skin rejuvenation / Fotofacial
- Sunscreen advice
- Laser Hair Removal
- Microdermabrasion
- Skin care advice or products
- Botox
- Sclerotherapy (Spider Veins)
- Facials
- Light Therapy for acne
- Intense Pulse Light (age spots, fine lines and wrinkles)
- Fractional nonablative skin resurfacing

How did you hear about our practice?

- Physician, _____
- Insurance company
- Yellow pages
- A friend or family member _____
- Internet
- Advertisement or article _____

What cosmetic procedures, if any, have you had in the past?

Were you pleased with the outcome? If not, why?

May we notify you by email with information about our practice and specials or promotions to you?

Yes or No

- **If yes, please print your email address:** _____

I hereby declare that I have honestly and completely answered the above questions to the best of my knowledge. I understand that it is my obligation and responsibility to notify Dr. Martha E. Stewart of any changes in my medical condition or medication during the course of my medical treatments or at follow up visits.

Patient Signature

Date

Reviewed by

Date