DESERT MEDICAL REJUVENATION
REGAIN YOUR YOUTHFUL APPEARANCE

MEDICAL HISTORY

ART QUINTANILLA, M.D.

COSMETIC HISTORY

Which of the following best describes your skin type? (Please circle one number type)

I. Always burns, never tans

II. Always burns, sometimes tans

III. Sometimes burns, always tans

IV. Rarely burns, always tans

V. Brown, moderately pigmented skin

VI. Black

ALLERGIES

Are you allergic to any medications? ( ) YES ( ) NO
If yes, please list:_____
Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced)
( ) Food ( ) Latex ( ) Aspirin ( ) Lidocaine ( ) Hydrocortisone ( ) Hydroquinone or bleaching agents
Others:_____

MEDICATIONS

Please list all medications you are currently taking (including prescriptions, over-the-counter meds, and vitamins):
Prescriptions: _____
Over-the-counter:_____
What topical medications or creams are you currently using? ( ) Retin-A ( ) Others: _____

FOR FEMALE PATIENTS

Are you pregnant or trying to become pregnant?	( ) YES ( ) NO
Are you breastfeeding?	( ) YES ( ) NO
Are you using contraception?	( ) YES ( ) NO
Are you on hormones or hormone replacement therapy?	( ) YES ( ) NO

DESERT MEDICAL REJUVENATION 35900 BOB HOPE DRIVE SUITE 130 RANCHO MIRAGE, CA 92270 (760)832-7279

REVIEW OF SYSTEMS

Do you have now, or have you ever had any of the listed diseases or conditions? (Please check all that apply)

DERMATOLOGY
( ) oily skin
( ) dry skin
( ) red or brown spots
( ) fine lines/wrinkles
( ) sun damage

GENERAL
( ) diabetes
( ) reaction to antibiotics
( ) reaction to bandages
( ) anticoagulant daily

ENDOCRINE
( ) excessive sweating
( ) heat/cold intolerance

MUSCULOSKELETAL
( ) arthritis/joint deformity
( ) artificial joints

GASTROENTEROLOGY
( ) nausea
( ) vomiting
( ) gastro-intestinal problems

PSYCHOLOGY
( ) depressions
( ) suicidal thoughts
( ) mental or physical abuse
( ) mood swings
( ) obsessive-compulsive

BLOOD/LYMPH
( ) swollen glands
( ) fatigue
( ) varicose veins
( ) easy bruising
( ) bleed easily
( ) blood clots
( ) thyroid problems

CARDIOLOGY
( ) chest pain
( ) palpitations
( ) leg swelling
( ) heart attack
( ) high blood pressure
( ) pacemaker

NEUROLOGY
( ) headaches
( ) tingling/numbness
( ) seizures/dizziness

RESPIRATORY
( ) asthma
( ) chest tightness
( ) cough/wheezing
( ) bronchitis
( ) emphysema

BIOLOGICAL FAMILY HISTORY | DK= DON'T KNOW

Have any family members had the following?

Tuberculosis	( ) YES	( ) NO	( ) DK	Who_____
Heart disease (before 55 years old)	( ) YES	( ) NO	( ) DK	Who_____
High cholesterol/takes cholesterol medication	( ) YES	( ) NO	( ) DK	Who_____
Anemia	( ) YES	( ) NO	( ) DK	Who_____
Bleeding disorder	( ) YES	( ) NO	( ) DK	Who_____
Cancer or skin cancer (before 55 years old)	( ) YES	( ) NO	( ) DK	Who_____
Liver disease	( ) YES	( ) NO	( ) DK	Who_____
Kidney disease	( ) YES	( ) NO	( ) DK	Who_____
Diabetes (before 55 years old)	( ) YES	( ) NO	( ) DK	Who_____
Obesity	( ) YES	( ) NO	( ) DK	Who_____
Epilepsy or convulsions	( ) YES	( ) NO	( ) DK	Who_____
Alcohol abuse	( ) YES	( ) NO	( ) DK	Who_____
Drug abuse	( ) YES	( ) NO	( ) DK	Who_____
Mental illness/depression	( ) YES	( ) NO	( ) DK	Who_____
Developmental disability	( ) YES	( ) NO	( ) DK	Who_____
Immune problems, HIV, or AIDS	( ) YES	( ) NO	( ) DK	Who_____
Tobacco use	( ) YES	( ) NO	( ) DK	Who_____

Additional Family History_____

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PAST MEDICAL HISTORY

Are you currently under the care of a physician?	( ) YES	( ) NO	If yes, for what?_____
Are you currently under the care of a dermatologist?	( ) YES	( ) NO	If yes, for what?_____
Do you drink alcohol?	( ) YES	( ) NO	If yes, how many per day?_____
Do you smoke?	( ) YES	( ) NO	If yes, how many per day?_____
Any Dental Procedures in the past 2 weeks?	( ) YES	( ) NO	If yes, which?_____
Any Vaccination in the past 2 weeks?	( ) YES	( ) NO	If yes, which?_____
Have you ever been exposed to HIV (AIDS) or Hepatitis?	( ) YES	( ) NO	

List any surgical procedures you've had in the last year:_____

Height:_____ Weight:_____

History of:

Asthma, bronchitis, bronchiolitis, or pneumonia	( ) YES	( ) NO	( ) DK	Explain_____
Any heart problem or heart murmur	( ) YES	( ) NO	( ) DK	Explain_____
Anemia or bleeding problem	( ) YES	( ) NO	( ) DK	Explain_____
Blood transfusion	( ) YES	( ) NO	( ) DK	Explain_____
HIV or sexual transmitted infections	( ) YES	( ) NO	( ) DK	Explain_____
Organ transplant	( ) YES	( ) NO	( ) DK	Explain_____
Malignancy/bone marrow transplant	( ) YES	( ) NO	( ) DK	Explain_____
Chemotherapy	( ) YES	( ) NO	( ) DK	Explain_____
Frequent abdominal pain	( ) YES	( ) NO	( ) DK	Explain_____
Constipation requiring doctor visits	( ) YES	( ) NO	( ) DK	Explain_____
Recurrent urinary tract infections and problems	( ) YES	( ) NO	( ) DK	Explain_____
Cancer or skin cancer?	( ) YES	( ) NO	( ) DK	Explain_____
Kidney disease or urologic malformations	( ) YES	( ) NO	( ) DK	Explain_____
Chronic or recurrent skin problems (e.g. acne,	( ) YES	( ) NO	( ) DK	Explain_____
eczema)	( ) YES	( ) NO	( ) DK	Explain_____
Frequent headaches	( ) YES	( ) NO	( ) DK	Explain_____
Convulsions or other neurologic problems	( ) YES	( ) NO	( ) DK	Explain_____
Obesity	( ) YES	( ) NO	( ) DK	Explain_____
Diabetes	( ) YES	( ) NO	( ) DK	Explain_____
Thyroid or other endocrine problems	( ) YES	( ) NO	( ) DK	Explain_____
High blood pressure	( ) YES	( ) NO	( ) DK	Explain_____

I attest that the information I have provided above is correct, complete and current, realizing that the medical care provided to me may be based on this information.

Patient Name_____

Patient Signature_____ Date_____

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