THE
DERMATOLOGY & COSMETIC CARE CENTER

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PERSONAL MEDICAL HISTORY

CUTANEOUS VASCULOPROLIFERATIVE LESIONS

NAME:_____
DATE:_____
INSURANCE:_____

1. Are you consulting for?
   - __ Cosmetic purposes
   - __ Medical Purposes
   - __ Both

2. Indicate which symptoms you have experienced:
   - __ Flushing __ Blushing __ Itching
   - __ Stinging __ Burning __ Warmth
   - __ Pain __ Aching __ Heat
   - __ Other _____

3. In general, are your symptoms:
   - __ Intermittent __ Persistent __ Chronic
   - __ Daytime __ Evening
   - __ Recent onset? _____months/years

4. Signs you experience:
   - __ Rosy cheeks __ Red patches __ Red or blue lines or vessels
   - __ Bruising __ Sunburn-like areas __ Knobby bumps on the nose
   - __ Whiteheads __ Blackheads __ Cysts or nodules
   - __ Scaling areas __ Dilated pores __ Changes in color or size
   - __ Bleeding or crusting after minor trauma
   - __ Other _____

5. In general, are the above occurrences?
   - __ Intermittent __ Persistent __ Chronic
   - __ Recent onset? _____months/years

6. Are your signs or symptoms worsened by?
   - __ Sunlight __ Stress __ Exercise
   - __ Alcohol __ Menopause __ Menses
   - __ Medicines __ Foods
   - __ Other _____

7. Present or prior treatment:
   - Creams _____
   - Soaps _____
   - Moisturizers _____
   - Pillls _____

- ☐ Make-up or cover-up _____
- ☐ Sunscreens _____
- ☐ Sclerotherapy (when & where) _____
- ☐ Laser (when & where) _____

8. As a result of your vascular lesions do you experience?
   - __ Lessened self-esteem
   - __ Embarrassment
   - __ Self-consciousness
   - __ Constant need for make-up or cover-up
   - __ Lessened employability
   - __ Avoidance of social situations
   - __ Discomfort

9. Do you have a family history of?	No	Yes	Family Member
☐ Vein problems	____	____	_____
☐ Phlebitis (inflammation of a vein)	____	____	_____
☐ Blood clots	____	____	_____
☐ Leg ulcers	____	____	_____
☐ Easy bruising	____	____	_____
☐ Prolonged bleeding	____	____	_____
☐ Fainting or seizures	____	____	_____

10. Do you have a personal history of?

a. Medication problems	Allergies	Overreaction	Adverse Reaction
☐ Penicillin	_____	_____	_____
☐ Mycins	_____	_____	_____
☐ Other antibiotics	_____	_____	_____
☐ Aspirin	_____	_____	_____
☐ Codeine	_____	_____	_____
☐ Morphine	_____	_____	_____
☐ Tetanus	_____	_____	_____
☐ Antitoxin	_____	_____	_____
☐ Topical anesthetics (Lidocaine, Tetracaine, Xylocaine)	_____	_____	_____

	No	Yes
b. Allergies to cosmetics	____	____
c. Proneness to syncope or fainting spells	____	____
d. Proneness to bruising	____	____
e. Non-aesthetic scars and difficult skin healing	____	____
f. Sensitivity to pain	____	____

11. Have you suffered from one of the following?	No	Yes	Date
☐ Heart disease	____	____	_____
☐ Anemia	____	____	_____
☐ Jaundice	____	____	_____
☐ Hepatitis	____	____	_____
☐ Epilepsy	____	____	_____
☐ Migraine headaches	____	____	_____
☐ Diabetes	____	____	_____
☐ Skin cancer	____	____	_____
☐ High or low blood pressure	____	____	_____
☐ Nervous breakdown	____	____	_____
☐ Hay fever or asthma	____	____	_____
☐ Hives, eczema	____	____	_____
☐ Frequent infections or boils	____	____	_____

12. Have you ever had your veins treated?	No	Yes	Date
Sclerotherapy	____	____	_____
Laser therapy	____	____	_____
Electrocauterization	____	____	_____
Surgery	____	____	_____

13. Are you taking any medication(s)?	No	Yes
Aspirin	____	____
Anticoagulants	____	____
Hormones or contraceptives (birth control pills)	____	____
Chemocautery or any type of tumor	____	____
Thyroid medication	____	____
Cortisone	____	____
Insulin	____	____
Sedatives (sleeping pills)	____	____
Tranquilizers	____	____
Appetite depressants	____	____
Antabuse	____	____
Others	____	____

Specify: _____

	No	Yes
14. Does your work require prolonged exposure to the sun or elements?	____	____
15. Do you smoke? If yes, how many per day? _____	____	____
16. Do you drink? If yes, how many drinks per day? _____	____	____
17. Have you ever had a blood transfusion?	____	____
18. Present illness (if any) Specify: _____ _____	____	____
19. Do you have any idea of your exposure or contamination to the AIDS disease?	____	____

	No	Yes	Date
20. Have you been tested for AIDS? Results: _____	____	____	_____
21. Have you ever been tested for Hepatitis? Results: _____	____	____	_____
22. Have you ever been vaccinated for Hepatitis?	____	____	_____
23. Have you been immunized against?			
□ Small pox	____	____	_____
□ Tetanus	____	____	_____
□ Polio	____	____	_____

24. Indicate the date of your last: Physical examination _____ Laboratory tests _____

25. Have you had X-Rays of?	No	Yes	Date
☐ Chest	____	____	_____
☐ Stomach	____	____	_____
☐ Gall Bladder	____	____	_____
☐ Extremities	____	____	_____
☐ Back	____	____	_____
☐ Cancer Therapy	____	____	_____
☐ Other	____	____	_____
☐ Specify: _____			

26. Systems review:	No	Yes
☐ Any eye disease, injury or impaired sight	____	____
☐ Any ear disease, injury or impaired hearing	____	____
☐ Any trouble with nose, sinuses, mouth or throat	____	____
☐ Convulsions	____	____
☐ Paralysis	____	____
☐ Dizziness	____	____
☐ Frequent or severe headache	____	____
☐ Enlarged glands	____	____
☐ Enlarged goiter	____	____
☐ Skin disease	____	____
☐ Cough, frequent or chronic	____	____
☐ Chest pain or angina pectoris	____	____
☐ Spitting up blood	____	____
☐ Night sweats	____	____
☐ Shortness of breath	____	____
☐ Palpation or fluttering heart	____	____
☐ Liver disease or gall bladder disease	____	____
☐ Colitis or other blood disease	____	____

27. Please describe in detail any comments or symptoms you are experiencing as a result of your condition. _____

28. Is there any additional information, which you would consider pertinent? _____

29. Do you wish to be included in our periodic follow-up assessment recall list? _____

30. Do you wish to receive our newsletters and educational updates? _____