

AESTHETIC LASER SURGERY & DERMATOLOGY, Ltd.

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(937) 438-3376

PATIENT MEDICAL INFORMATION

DATE: _____ PATIENT: _____ DATE OF BIRTH: _____

HAVE YOU HAD OR ARE YOU CURRENTLY BEING TREATED FOR ANY OF THE FOLLOWING:

(Place a check mark beside any that apply and date of incident)

- | | |
|--|--|
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Heart Bypass Surgery/Date _____ |
| <input type="checkbox"/> Pre Skin Cancer Lesions | <input type="checkbox"/> Artificial Heart Valve/Date _____ |
| <input type="checkbox"/> Dysplastic Nevus/Nevi | <input type="checkbox"/> Abnormal Heart Beats |
| <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Squamous Cell Carcinoma | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Melanoma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Kidney Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> COPD | <input type="checkbox"/> On Dialysis |
| <input type="checkbox"/> Allergies/Hay Fever | <input type="checkbox"/> Liver Cancer |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Thyroid Cancer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Scleroderma | <input type="checkbox"/> Colon Cancer |
| <input type="checkbox"/> History of Fainting | <input type="checkbox"/> Breast Cancer |
| | <input type="checkbox"/> Other _____ |

DO ANY CLOSE RELATIVES HAVE ANY OF THE FOLLOWING?

Melanoma Lupus Psoriasis

PLEASE LIST PRIOR SURGERIES AND DATES IF NOT LISTED ABOVE:

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

PLEASE LIST ALLERGIES TO MEDICATIONS:

PLEASE CHECK IF YOU ARE ALLERGIC TO: Tape Latex Local Anesthetics

DO YOU SMOKE? Yes No If Yes, How long? _____

DO YOU DRINK? Yes No If Yes, How many drinks per week: _____

Doctor's Use Only

Updated: _____ Updated: _____ Updated: _____ Updated: _____ Updated: _____

Updated: _____ Updated: _____ Updated: _____ Updated: _____ Updated: _____