ART QUINTANILLA, MD
BOARD CERTIFIED PHYSICIAN

DESERT MEDICAL REJUVENATION

MEDICAL HISTORY FORM

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
REGAIN YOUR YOUTHFUL APPEARANCE

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

PHSYCHOLOGY
( ) 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 _____

DESERT MEDICAL REJUVENATION
REGAIN YOUR YOUTHFUL APPEARANCE

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?_____
Have you ever been exposed to HIV (AIDS) or Hepatitis? ( ) YES ( ) NO
List any surgical procedures you have had in the past 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, 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**_____