CALIFORNIA SKIN INSTITUTE

Select the appropriate office location

Patient Medical History Form

San Jose/Los Gatos
2420 Samaritan Drive
San Jose, CA 95124

Mountain View
525 South Drive,Suite 115
Mountain View, CA 95040

San Jose / O'Connor
2100 Forest Avenue, Suite 103
San Jose, CA 95128

Saratoga
18988 Cox Avenue Suite B
Saratoga, CA 95070

Los Altos
129 Fremont Avenue
Los Altos, CA 94022

Monterey/Ryan Ranch
9781 Blue Larkspur Lane, St Suite 100
Monterey, CA 93940

San Mateo
136 North San Mateo Drive,2nd Floor
San Mateo, CA 94401

San Francisco Lauriel Heights
3905 Sacramento Street Suite 201
San Francisco, CA 94118

San Francisco Pacific Heights
2100 Webster Street, Suite 318
San Francisco, CA 94115

Salinas
559 Abbott Street,Suite A
Salinas, CA 93901

Santa Cruz County
204 Green Valley Road
Freedom, CA 95019

Monterey
977B Pacific st
Monterey, CA 93940

South San Jose
393 Blossom Hill Road,Suite 290
San Jose, CA 95123

Daly City
1800 Sullivan Avenue,Suite 403
Daly City, CA 94015

Castro Valley
20055 Lake Chabot Rd Ste 150
Castro Valley, CA 94546

Are you in good general health now ? Yes ◯ No ◯

Have you ever had any of the following ?

Asthma	Yes ◯	No ◯		Diabetes	Yes ◯	No ◯
Chronic Hay Fever	Yes ◯	No ◯		Internal Cancer	Yes ◯	No ◯
Hives	Yes ◯	No ◯		High Blood Pressure	Yes ◯	No ◯
Sinus Problems Migraines	Yes ◯	No ◯		Heart Trouble	Yes ◯	No ◯
Eczema	Yes ◯	No ◯		Rheumatic Fever	Yes ◯	No ◯
Boils	Yes ◯	No ◯		Jaundice/Hepatitis	Yes ◯	No ◯
Food Allergies	Yes ◯	No ◯		Kidney Diseas	Yes ◯	No ◯
Allergy to Local Anesthetics	Yes ◯	No ◯		Glaucoma	Yes ◯	No ◯
Bleeding Tendency r	Yes ◯	No ◯		Epilepsy	Yes ◯	No ◯
				Tuberculosis	Yes ◯	No ◯
Ulcer	Yes ◯	No ◯		Organ Transplant	Yes ◯	No ◯
HIV Infection	Yes ◯	No ◯		Joint Replacement	Yes ◯	No ◯
Do you smoke ?	Yes ◯	No ◯		Do you take blood thinners? e.g.Aspirin, Advil, Ibuprofen,Motrin?	Yes ◯	No ◯

Women only, please answer the following

Are you pregnant ? Yes ◯ No ◯

If yes, your expected delivey date

Are you currently breast feeding? Yes ◯ No ◯

Do you take birth control pills? Yes ◯ No ◯

If yes, what brand ?

What diseases, if any, run in your family?

Have you ever been treated for skin cancer? Yes ◯ No ◯

List all prescription and non-prescription medications you are now or have recently taken for any problem (including your skin):

If you are allergic to any medication, please list them

Have you ever taken Penicillin? Yes ◯ No ◯

Did you have a reaction to it?If so, describe reaction: Yes ◯ No ◯

Previous skin problems? Please describe below:

Serious illness? Please describe below:

Any hospitalizations? Please describe below:

Any surgeries? Please describe below:

Patient's Printed Name:

Date