Acct # _____

Skin Revitalizing Center
Jack A. Dekkinga, MD PC

Jack A. Dekkinga, MD Susan K. Barry, PA-C Molly Duiven, PA-C Dawn Gelder, CMT

Medical History Form

Name: _____ Date of Birth: _____

Medications:

Please provide an accurate, up to date list of your current medications:

_____

_____

Have you used Retin A, Retin A Micro, or Renove in the last 7 days? □ Yes □ No
What strength? _____
How often do you use it? _____

Are you currently or have you ever taken Accutane? □ Yes □ No
How many months? _____
How often do you use it? _____

Are you taking herbal preparation? (St Johns, Wort) □ Yes □ No
If yes, please list: _____

Allergies:

Please circle any of the following allergies that you are aware of:

DRUG	**FOOD**	**ENVIRONMENT**
ACE Inhibitors	Citrus	Adhesive Tape
Aloe Vera	Grapes	Animal Dander
Aspirin	Milk	Dust
Cephalosporins	Mushrooms	General
Codeine/or Derivates	Nuts	Latex
Hydroquinone	Seafood/Shellfish	Mites
Kojic Acid	OTHER:	Mold Spores
Local Anesthetics		OTHER:
Neosporins		
NSAIDS		
Penicillins		
Polysporin		
Sulfa Drugs		
Tetracyclines		
Topical Antifungals		
OTHER:		

Do you have any skin related allergies? □ Yes □ No
If yes, please specify: _____

Past Medical History

Do you wear contact lenses? □ Yes □ No
(must be removed prior to microdermabrasions)
Do you have a history of cold sores or fever blisters? □ Yes □ No
Do you take medication for cold sores? □ Yes □ No
Last Breakout: _____
Medication used? _____
Have you tanned your face in a tanning booth in the past 3 weeks? □ Yes □ No

Do you tan your face in the sun or tanning booth on a regular basis? □ Yes □ No
Do you have history of keloid scarring? □ Yes □ No

Do you have a history of any of the following?

□ Yes	□ No	Heart Disease	□ Yes	□ No	Diabetes
□ Yes	□ No	Bruising	□ Yes	□ No	Bleeding Disorders
□ Yes	□ No	Skin Injury	□ Yes	□ No	Dark spots after pregnancy
□ Yes	□ No	Skin cancer, or suspicious moles			

Social History

ALCOHOL USE: None Occasional Moderate Heavy Recently Quit

TOBACCO USE: None How Long? _____ Recently Quit Would like to Quit?

Cigarettes ppd_____ Pipe Cigars Chewing Tobacco Snuff

PETS/ANIMALS Dog Cat OTHER:

ARE YOU A VEGETARIAN? □ Yes □ No

Pregnancies

Are you pregnant?	□ Yes	□ No	If Pregnant, Due Date? _____
Are you lactating?	□ Yes	□ No	
Are you planning a pregnancy soon?	□ Yes	□ No	

By signing this form, I admit, that to the best of my knowledge, the above information is complete and accurate as of the date indicated below.

Signature: Date

In case of emergency, whom should we contact?

Name: _____

Address:_____

City, State, Zip_____

Phone #: _____

Relationship: _____