

GARY C. LEE, PH. D., M. D. INC.
PATIENT MEDICAL HISTORY
(Please Print)

Today's date: _____

Patient: _____ Birthplace: _____

Are you allergic to any medications? ____yes ____no. If yes, please list: _____

List all medications you are currently taking (including prescriptions, over-the-counters meds., vitamins and herbals):

- | | | |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

Do you have now, or have you ever had diseases or conditions of: (please check YES or NO)

History of premalignant skin lesions ____YES ____NO	History of prior skin condition ____YES ____NO
History of malignant skin lesions ____YES ____NO	History or skin condition ____YES ____NO
History of prior skin surgeries ____YES ____NO	Any other area of sun damage? ____YES ____NO
History of other malignancy ____YES ____NO	Do you have a pacemaker? ____YES ____NO
Do you take prophylactic antibiotics prior to surgery? ____YES ____NO	Do you have any bleeding tendencies? ____YES ____NO
Any history of X-ray treatment of skin disorder? ____YES ____NO	Inflammation/blood clots ____YES ____NO
History of skin cancer in family? ____YES ____NO	Do you have any problem with healing? ____YES ____NO
Do you develop keloids (scars) after surgery? ____YES ____NO	Do you bleed easily? ____YES ____NO

List any other disease or conditions: _____

List any surgical procedures you have had in the last 6 months: _____

Past Medical Families and Social History:

History or blood transfusions (reason/date): _____

Other Medical Problems: _____

Have you been in any high risk category for AIDS (acquired immune deficiency syndrome) or exposed to HIV (human immune virus) or have a history of Hepatitis: _____

History of genetic disease: _____

Please answer the following questions:

(Women) Are you pregnant? ____YES ____NO

What is your occupation? _____

I certify that I have completely disclosed my medical history and to the best of my knowledge have not withheld any medical information from this.

Completed and Signed by: _____ Date: ____/____/____

Patient/Parent or Responsible Party Signature