



146 West Pine Street  
Ponchatoula, LA 70454  
985-370-1762, opt #3

**Current Medications:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Medical History:**

**Please check all that apply:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Rash                          |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Rheumatic Fever               |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Scarlet Fever                 |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> HIV                     | <input type="checkbox"/> Shingles                      |
| <input type="checkbox"/> Bladder Infection   | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Stroke                        |
| <input type="checkbox"/> Bleeding Tendency   | <input type="checkbox"/> Measles                 | <input type="checkbox"/> Thyroid Disorder              |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Melanoma                | <input type="checkbox"/> Tuberculosis                  |
| <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Migraine Headaches      | <input type="checkbox"/> Venereal Disease              |
| <input type="checkbox"/> Dementia            | <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Whooping Cough                |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Mumps                   | <input type="checkbox"/> Other History (explain below) |
| <input type="checkbox"/> Epilepsy/Seizures   | <input type="checkbox"/> Pacemaker/Defibrillator |  |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Pregnant                |  |

Other History: \_\_\_\_\_

**Skin History:**

**Please check all that apply:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> No significant skin history | <input type="checkbox"/> Eczema                        | <input type="checkbox"/> Shingles                |
| <input type="checkbox"/> Abnormal Mole               | <input type="checkbox"/> Keloids/Hypertrophic Scarring | <input type="checkbox"/> Squamous Cell Carcinoma |
| <input type="checkbox"/> Acne                        | <input type="checkbox"/> Malignant Melanoma            | <input type="checkbox"/> Tinea                   |
| <input type="checkbox"/> Actinic Keratosis           | <input type="checkbox"/> Other suspicious lesion       | <input type="checkbox"/> Urticaria/Hives         |
| <input type="checkbox"/> Basal Cell Carcinoma        | <input type="checkbox"/> Psoriasis                     |  |
| <input type="checkbox"/> Dermatitis                  | <input type="checkbox"/> Rosacea                       |  |

**Surgical History:**

No past surgeries or hospitalizations  
 Surgeries: \_\_\_\_\_