Loftus Total Skin Care

MEDICAL HISTORY FORM

INSTRUCTIONS: 1. Print this form. 2. Fill it out entirely. 3. Scan (if using an iphone: Open Notes/New note/touch the camera icon/select “scan document”) 4. Please scan it rather than taking a photo of this document

Name: ____ **Date** ______________________________

Age:_____ **Height:** ________ **Weight:** ____ **D.O.B.** _________ **Occupation:** ____________________________

Have you ever been seen by Dr. Loftus? __ **No** __ **Yes** If yes, list procedures: ________________________

How did you hear about Loftus Total Skin Care? ____

Smoker? No Yes, I currently smoke _________ packs/day Quit (when) ____________

Prescription Medications: ____

Supplements: ____

ASPIRIN/NSAIDs (List usage): ____

Allergies to any Medications (List reaction): ____

PLEASE CIRCLE YES OR NO FOR EACH ITEM:

Y N Heart palpitations	Y N Hepatitis	Y N Glaucoma
Y N Heart valve problems Y N	Y N Blood clots	Y N Psychological problems
Y N Heart attack	Y N Bleeding tendencies	Y N Depression/Anxiety
Y N High blood pressure	Y N Auto Immune Disorder	Y N Positive HIV test (ever)
Y N Diabetes	Y N Intestinal problems	Y N Allergy to latex or adhesives
Y N Asthma/Emphysema	Y N Thyroid problems	
Y N Shortness of breath	Y N Arthritis	Y N Joint Replacement
Y N Cold Sores (Site:__________Y N)	Y N Shingles (Site:_________)	Y N Other (List Below)

Other medical problems not listed above: ____

List ALL Past Surgeries: ____

I certify that the above information is complete and accurate: **X**________________________________

(Patient Signature)

Clinician Use:

History: ☐ Noncontrib. ☐ See notes

Exam:

Skin: ☐ No dz ☐ See notes

Heart: ☐ RRR ☐ See notes

Pulm: ☐ CTA ☐ See notes

Extr: ☐ Perfused ☐ See notes

Other: ☐ N/a ☐ See notes

Notes:

Impression:

☐ This patient is an appropriate candidate for all LTSC treatments.

☐ This patient is NOT an appropriate candidate for: ☐ Injectable Anesthesia:_____________ ☐ Topical Anesthesia ☐Exilis ☐Filler ☐Botox ☐PMUP ☐Peels (type):___________ ☐ Laser (type):_____________

☐ Other:

____

Treatment Plan:

☐ Proceed with treatment according to LTSC protocol, including antiviral prophylaxis for Vitalize, 3-Step, Microneedling, DOT C02

☐ Proceed with treatment in accordance with the following special instructions: ________________________

____

Date: ___________________________ __________________________________, MD or NP

(Signature of MD or NP)

• in-person • telemed

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