JOHN E. VINE, M.D.
DERMATOLOGY & SKIN SURGERY CENTER OF PRINCETON
PATIENT HEALTH EVALUATION

Name: _____ **Date**: _____
Telephone: _____ **Referred by (fill in)**:
Date of Birth: _____ **Physician**: Dr. _____
Age: _____ **Height**: _____ **Weight**: _____ **Patient/Friend**: _____
Occupation: _____ **Other**: _____

Please fill in the following:
Do you have dentures? _____ Do you take antibiotics prior to dental work? _____
Drug Allergies (including local anesthetics): _____

Are you currently taking or using any of the following medications/substances?:

	Yes	No	Date Last Taken
Coumadin	___	___	_____
Plavix	___	___	_____
Pradaxa	___	___	_____
Insulin	___	___	_____
Antibiotics	___	___	_____
Digoxin	___	___	_____
Steroids	___	___	_____
Aspirin	___	___	_____
Tobacco Products (start Date:)	___	___	_____
Alcohol (circle: Socially Daily Weekly)	___	___	_____
Accutane	___	___	_____

Please list all other medications / drugs you are taking at the present time:

_____ _____ _____
_____ _____ _____

Do you have or have you ever had any of the following conditions?

	Yes	No		Yes	No
Heart Murmur/Trouble	___	___	Epilepsy	___	___
Artificial Heart Valve	___	___	Bleeding Tendency	___	___
Pacemaker	___	___	Hepatitis (Type)	___	___
Defibrillator	___	___	HIV/AIDS	___	___
Hip/Knee Replacement	___	___	Lupus	___	___
Keloid Scarring	___	___	Rheumatoid Arthritis	___	___
History of MRSA infection	___	___	Organ Transplant	___	___
Cold Sores	___	___	Cancer/Skin Cancer (Type:)	___	___
Rheumatic Fever	___	___	Leukemia	___	___
Kidney Trouble	___	___	Lymphoma	___	___
High Blood Pressure	___	___	Multiple Myeloma	___	___
Diabetes	___	___	Immunosuppressed	___	___

Please indicate any aesthetic/cosmetic concerns:

☐ Fine lines and wrinkles ☐ Hollowing cheeks ☐ Broken capillaries
☐ Uneven skin tone ☐ Deep lines ☐ Thinning lips
☐ Brown/dark spots ☐ Leg veins ☐ Other