Hala Koudsi, M.D., Inc
Dermatology & Skin Cosmetic Surgery

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Medical History

Patient Name

Are you allergic to any medications? ☐ Yes ☐ No If yes, Please list:

1. 2.

List all medications you are currently taking:

When you are exposed to sun do you? ☐ Tan only ☐ Tan & Burn ☐ Burn

Have you ever had skin cancer? ☐ Yes ☐ No

Has anyone in your family had skin cancer? ☐ Yes ☐ No

Has anyone in your family had malignant melanoma? ☐ Yes ☐ No

Do you have history of specific skin disease? ☐ Yes ☐ No If yes, please list:

1. 2.

Are you experiencing recent or chronic hair losses? ☐ Yes ☐ No

List any other disease or condition we should know about:

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

Please answer the following questions:

Do you smoke: ☐ Yes ☐ No If yes, how much:

Are you pregnant: ☐ Yes ☐ No Due date:

Do you have artificial joints: ☐ Yes ☐ No Do you bleed easily: ☐ yes ☐ No

History of Diseases

Please check if you have now, or have you ever had diseases or conditions of:

Lung
- Bronchitis ○
- Emphysema ○
- Asthma ○
- Hay Fever ○
- Chronic Cough ○
- Morning Cough ○
- Thyroid ○

Vascular
- High Blood Pressure ○
- Chest Pain ○
- Heart Attack ○
- Heart Murmur ○
- Irregular Heart Beat ○
- Pacemaker ○

Systemic
- Diabetes ○
- Kidney ○
- Bladder ○
- Stomach ○
- Bowel ○
- Hepatitis ○
- Yellow Skin ○
- Convulsions ○
- Fainting ○
- Glaucoma ○
- Alcohol ○
- AIDS ○
- Phlebitis ○

Patient Signature Date

Physician Signature