SHILOH MEDICAL CLINIC
BILLINGS & BOZEMAN

MEDICAL HISTORY

Date: ______/______/__________

Name: ____ **Gender: F M** **Age:** ________ **Date of Birth:** ____/____/_____

Address: ______________________________________ **City:** ___________________ **State:** _______ **Zip:** ______________

[ ] **I agree to receive email communications from Shiloh Medical Clinic.** **Email:** ______________________________________

[ ] **I agree to receive text message communications from Shiloh Medical Clinic including appointment reminders, updates and occasional promotional messages related to service specials.** **Cell: (______)_________--______________**

Alternative phone #'s: **Home Phone: (______)_______--____________** **Work: (______)_______--______________**

Spouse/Emergency Contact: ____ **Phone: (______)_______--____________**

Occupation: ____ **Employer:** ____

How did you hear about us? ☐ Television ☐ Newspaper ☐ SMC Website ☐ Billboard ☐ Internet
☐ Magazine ☐ Facebook ☐ Instagram ☐ Family ______________
☐ Friend _________________ Other: __________________________________

SKIN HISTORY	**YES**	**NO**
Skin Cancer	☐	☐
Recent Sun Burn	☐	☐
Accutane, Last 6 Months	☐	☐
Gold Therapy	☐	☐
Cold Sores	☐	☐
Genital Herpes	☐	☐
Shingles	☐	☐
Rosacea	☐	☐
Vitiligo	☐	☐
Keloid Scarring	☐	☐
Tattoos/Permanent Make-Up	☐	☐
Implants/Surgeries in Treatment Area	☐	☐
Ever had a reaction to a skin treatment?	☐	☐
Ever had an allergic reaction to a skin product?	☐	☐
Do you use sunscreen?	☐	☐
Retin-A, Hydroquinone or Topical Steroid use?	☐	☐
Do you take Coumadin, Plavix, or Aspirin?	☐	☐

SURGICAL HISTORY_____________________________________

ALLERGIES____

SOCIAL HISTORY

Marital Status ☐ Married ☐ Single
☐ Divorced ☐ Widowed

MEDICAL HISTORY_____________________________________

MEDICATIONS (INCLUDE VITAMINS/HERBS)

Name **Dose**