

DATE: \_\_\_/\_\_\_/\_\_\_

NAME: \_\_\_\_\_

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**MEDICAL HISTORY**

Prior skin problems or skin cancer? \_\_\_\_\_

Allergies to any medication? \_\_\_\_\_

High Blood Pressure? \_\_\_\_\_ Diabetes? \_\_\_\_\_

Liver disease or hepatitis? \_\_\_\_\_ Kidney disease? \_\_\_\_\_

Lung problems? \_\_\_\_\_

Glaucoma? \_\_\_\_\_ Stomach problems or ulcers? \_\_\_\_\_

Hay fever, asthma, eczema, sinus or eye allergies? \_\_\_\_\_

Collagen Vascular disease or auto immune diseases? \_\_\_\_\_

Cancer? \_\_\_\_\_ Immune deficiency? \_\_\_\_\_

**Other**

Occupation? \_\_\_\_\_

Do you smoke cigarettes? Yes \_\_\_\_\_ No \_\_\_\_\_ Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_

**MEDICATIONS**

PLEASE LIST ALL THE MEDICATIONS YOU ARE TAKING.

Oral (include birth control pills and vitamins)

1.	4.	7.
2.	5.	8.
3.	6.	9.

*It is the responsibility of each patient to notify their physician of any new medications to avoid drug interactions*

**SKIN CARE**

Please list all products you use on your skin (include make-ups, sunscreen and moisturizers)

1.
2.
3.
4.
5.