

Medical History


Medical History								
Patient Name	:	sandhya rani			Emirates ID	:	784-1996-9294842-7	
File No	:	7	DOB	:	2023-10-09	Nationality	:	Other
Gender	:	Female	Doctor's Name	:	dermatology derma	Date	:	2024-02-22

Please complete the following questionnaire.

	YES	NO	DETAILS
Are you currently pregnant, breast feeding or on fertility treatment? (if yes, please specify)	<input type="radio"/>	<input checked="" type="radio"/>	hfgfhgh
Do you suffer from allergies? (if yes, please specify)	<input type="radio"/>	<input checked="" type="radio"/>	hfhghfg
Have you ever suffered from anaphylaxis as a result? (if yes, please specify)	<input type="radio"/>	<input checked="" type="radio"/>	hfhfhggh
Are you currently receiving any medical treatment? (if yes, please specify)	<input type="radio"/>	<input checked="" type="radio"/>	hfhghfgh
Have you ever had a non-surgical treatment before? (if yes, please specify)	<input type="radio"/>	<input checked="" type="radio"/>	hfgfhgh
Have you ever had a reaction after receiving treatment? (if yes, please specify)	<input checked="" type="radio"/>	<input type="radio"/>	hfgfhghfgh
Do you suffer from any illnesses? e.g. angina, epilepsy, diabetes, auto immune system, hepatitis, HIV positive..? (if yes, please specify)	<input checked="" type="radio"/>	<input type="radio"/>	hfgfhghfgh
Do you suffer from any cutaneous infection or inflammatory problems? e.g. herpes/ acne. (if yes, please specify)	<input checked="" type="radio"/>	<input type="radio"/>	hgfhghf
Are you currently taking aspirin, steroids or anticoagulants (warfarin)? (if yes, please specify)	<input checked="" type="radio"/>	<input type="radio"/>	hfgfhgh
Have you recently undergone surgery? (if yes, please specify)	<input type="radio"/>	<input checked="" type="radio"/>	hfgfhghgf
Do you suffer from high or low blood pressure? (if yes, please specify)	<input type="radio"/>	<input checked="" type="radio"/>	hfhghfgh
Are you prone to bruising?	<input type="radio"/>	<input checked="" type="radio"/>	hfgfhgh

Procedure

hfgfhgh

Sign here, only if all of your questions have been answered to your satisfaction	
Patient	Doctor
	<div style="border: 1px solid black; width: 100px; height: 100px; margin: 0 auto;"></div>

<div>Patient Name</div> <div>sandhya rani</div> <div>Date</div> <div>2024-02-22</div>	<div>Doctor Name</div> <div>dermatology derma - Dermatology (0)</div> <div>Date</div> <div>2024-02-22</div>
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