



Medical History for Skin Care and Procedures

Name: _____	
Address: _____	
Phone #1: _____	Phone #2: _____
Female <input type="checkbox"/> Male <input type="checkbox"/> Age: _____	Referred by: _____

Reason for consultation

- | | |
|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Flushing of the skin |
| <input type="checkbox"/> Brown spots or sun damage | <input type="checkbox"/> Skin laxity |
| <input type="checkbox"/> Enlarged blood vessels | <input type="checkbox"/> Skin texture or scars |
| <input type="checkbox"/> Fine lines or wrinkles | <input type="checkbox"/> Unwanted hair |

Questions about skin

- How long have you been concerned about this area(s)? _____
- At what age did you notice this concern(s)? _____
- Are your present skin concern(s) getting more pronounced? Yes No
- Have you ever been treated for this concern(s)? Yes No
If yes, when? _____
What method? _____
- Are you currently taking medication for your skin's concern(s)? Yes No
If yes, what is it? _____
- What topical skin medications or products are you currently taking?
 Retin-A® Hydroquinone or bleaching agent Other _____
- Have you ever had laser / IPL hair removal? Yes No
- Have you ever used the following hair removal methods in the past 6 weeks?
 shaving waxing electrolysis plucking/tweezing stringing depilatories
- Have you ever had skin resurfacing or rejuvenation or chemical peels? Yes No
- Have you ever had treatments for pigmented lesions? Yes No
- Do you form thick or raised scars (keloids) from cut or burns? Yes No
- Do you experience hyperpigmentation (redness) from burns, cuts, insect bites? Yes No
- Have you had cold sores or fever blisters? Yes No

Skin Type choices (when exposed to the sun for about 1 hour with no protection):

- | | |
|---|---|
| <input type="checkbox"/> Always burns, never tans | <input type="checkbox"/> Rarely, burns, always tans |
| <input type="checkbox"/> Always burns, sometimes tans | <input type="checkbox"/> Brown, moderately pigmented skin |
| <input type="checkbox"/> Sometimes burns, always tans | <input type="checkbox"/> Black skin |

1. When were you last exposed to the sun or tanning booth? _____
2. Do you use self tanners? Yes No
3. Are you planning a vacation in the sun? Yes No

Personal history:

1. Do you wear contact lenses? Yes No
2. Do you smoke? Yes No if yes _____ packs per day
3. Alcohol: Beer/Wine/Liquor Frequency: Never Rarely Socially Daily
4. Drugs: Marijuana/Cocaine/_____ Frequency: Never Rarely Socially Daily

Medical history:

1. Are you currently under the care of a physician? Yes No. If yes, for what:

2. Do you have any of the following?

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy or seizures	<input type="checkbox"/> HIV / Aids
<input type="checkbox"/> Any active infection	<input type="checkbox"/> Heart disease	<input type="checkbox"/> MRSA
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sensitive teeth
<input type="checkbox"/> Bruising	<input type="checkbox"/> Herpes simplex	<input type="checkbox"/> Skin cancer or moles
<input type="checkbox"/> Dark spots of pregnancy	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Skin injury
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hormone imbalance	<input type="checkbox"/> Vision deficits
<input type="checkbox"/> Other _____		
3. Do you have allergies to any of the following? (check all that apply) medications latex
 food plants anesthesia other _____
4. Do you take any of the following?

<input type="checkbox"/> Accutane	<input type="checkbox"/> Appetite depressants	<input type="checkbox"/> Insulin
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Aspirin or Ibuprofen	<input type="checkbox"/> Sedatives
<input type="checkbox"/> Anti-coagulants	<input type="checkbox"/> Cortisone or steroids	<input type="checkbox"/> Thyroid medication
<input type="checkbox"/> Anti-depressants	<input type="checkbox"/> Hormone/contraceptives	<input type="checkbox"/> Other _____
5. Are you taking herbal preparations or vitamins? (St. John's Wort, Vitamin E) Yes No

For Female Patients:

Are you pregnant or trying to become pregnant? Yes No Are you lactating? Yes No

I have answered the questions contained in this questionnaire to the best of my knowledge. I understand that it is my responsibility to inform my practitioner of any pre-existing and all health conditions while seeking treatment as a patient. I will update this information as it occurs. I understand and accept any risks of which I have been advised associated with the agreed upon skin treatments.

Signature: _____ **Date:** _____