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Medical History and Skin Care Questionnaire

Name ____________________________ Date of Birth _________ Sex _____ Date _________ Age_________

How did you first hear of us? (check all that apply):

□TV □Radio □ Internet Search □ Website □ Physician _____________
□ Family/Friend □ Newspaper □ Social Media ____________________ □ Other_________________

Who can we thank for referring you to us? ____

If you would like to be added to our email blast to learn about specials, promotions etc., please list your email address: ____

Medical History

Medical Conditions: (check any condition that applies to you or list them below):

□ Diabetes □ Cancer- Type________ □ Hypertension □ Neurological disease
□ Thyroid □ Bleeding disorder □ Lupus □ Myasthenia gravis
□ Hernia □ Rheumatoid Arthritis □ Raynaud's □ Migraine headaches

- ________________________________ • ________________________________
- ________________________________ • ________________________________
- ________________________________ • ________________________________
- ________________________________ • ________________________________

Surgical History (please list past surgeries, non-cosmetic)

- ________________________________ • ________________________________
- ________________________________ • ________________________________
- ________________________________ • ________________________________

Current Medications: **(list all prescriptions, over the counter, herbal, vitamins, & supplements)**

- ________________________________ • ________________________________
- ________________________________ • ________________________________
- ________________________________ • ________________________________
- ________________________________ • ________________________________

Medication Allergies ____

Other Allergies/Sensitivities (check all that apply):

□ Aspirin □ Metal □ Latex □ Caines (lidocaine, benzocaine)

Health Risk Assessment

Use of tobacco: □ Cigarettes Age started___________ Packs/amount per day: ________
□ Never used it □ Cigars Age Stopped _________
□ Used to but quit □ Pipe
□ Still use it □ Snuff/chew

Revision 10 (4-6-2016) tlh

What describes your use of alcoholic beverages? (may choose more than one)
□ Never a drinker □ 1-2 drinks weekly □ Drink heavy on weekends only □ I need help
□ 1-5 drinks per year □ 1-2 drinks daily □ Heavy drinker all week
□ 1-2 drinks per month □ 3 or more drinks daily □ One/both of my parents are alcoholics

Women Only (check all that apply):
□ Hysterectomy □ Tubal ligation □ I could be pregnant □ Post-menopause
□ Pregnant : Due date ____/____/____ □ Nursing until: ____/____/____
First day of your last menstrual period ____/____/____ Type of birth control used ____________________

Skin Care Questionnaire

Skin History (check all that apply)
□ Precancerous skin lesion □ Keloids □ Herpes, cold sores □ Eczema
□ Recurrent Skin Rash □ Acne □ Ulcers □ Psoriasis
□ Skin cancer (if so circle all that apply) Squamous, Basal cell, Melanoma □ Sun Poisoning

Have you ever taken Accutane? □ No □ Yes When was your last dose ____/____/____

When in the sun for one hour without protection do you (circle one)..........
I Always burn and never tan
II Always burn and sometimes tan
III Sometimes burn and sometimes tan
IV Never burn and always tan
V Asian, Mediterranean, Hispanic
VI African American

Present Skin Conditions (check all that apply)

□ Brown Spots or Age Spots □ Skin Pigmentation Problems □ Whiteheads or Blackheads
□ Facial Redness □ Broken Facial Capillaries □ Fine Lines & Wrinkles
□ Oily Skin □ Clogged Pores □ Leg Spider Veins or Varicose Veins
□ Dry, Flaky Skin □ Moles you would like removed □ Crusty or Scaly areas that never heal
□ Unwanted Tattoos □ Melasma □ Moles that have changed shape or color
□ Acne Scarring □ Enlarged Pores □ Rosacea
□ Uneven Texture □ Lax or Sagging Skin □ Dark Under-Eye Circles

□ Excessive Sweating (if so circle all that apply) Hands, Feet, Scalp, Underarms

Do you currently see a dermatologist? □ No □ Yes (Why?) ______________________________
Do you bruise easily? □ No □ Yes
What type of skin do you think you have? □ Dry □ Normal □ Combination □ Oily
Have you ever had a reaction to any skin care product? □ No □ Yes (what?) ______________________

What skin care products do you use during your daily routine? (include soaps, moisturizers, oils, etc)

Morning	Evening
1) ____________________	1) ____________________
2) ____________________	2) ____________________
3) ____________________	3) ____________________
4) ____________________	4) ____________________
5) ____________________	5) ____________________

Are you happy with your current skin care products? □ No □ Yes

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Cosmetic History (please list dates when applicable)	**Yes**	**No**	**Date**
Facial Plastic Surgery …………………………………………………	□	□	____/____/____
Other Cosmetic Surgery (please list) ___________________________	□	□	____/____/____
Dermal Filler Injections (what product?)________________________	□	□	____/____/____
Botox® or Other Toxins (what toxin?) ___________________________	□	□	____/____/____
Chemical Peels	□	□	____/____/____
Dermaplane or Microdermabrasion...	□	□	____/____/____
Skin Resurfacing (CO2, Microlaserpeel, etc)………..............................	□	□	____/____/____
Photorejuvenation (BBL and/or IPL)…...	□	□	____/____/____
Laser Treatment of Veins..	□	□	____/____/____
Sclerotherapy (injection) of veins...	□	□	____/____/____
Coolsculpting…………………………………………………………….	□	□	____/____/____

Which of the the following areas are you interested in making improvements? (check all that apply)

□ Eyelashes	□ Lips	□ Nose	□ Neck	□ Double chin
□ Chest	□ Arms	□ Hands	□ Abdomen	□ Thighs inner/outer
□ Feet	□ Cellulite	□ Face	□ Legs	

Hair Removal

Do you have unwanted hair on your body? □ No □ Yes (Where?) ______________________________________

	Yes	**No**	**Date**
Have you had hair removal by electrolysis?..................................	□	□	______________
Laser (IPL, BBL, etc.)...........	□	□	______________
Waxing?................................	□	□	______________
Threading……………………	□	□	______________
Other Means?.......................	□	□	______________

Do you use tanning beds? □ No □ Yes …………. If yes, when was the last session? ____/____/____

Do you use self tanners or spray tan? □ No □ Yes ………. If yes, when was last use? ____/____/____

When were you last exposed to the sun (tanning or working/playing outside)?...................____/____/____

Do you have a vacation or sun exposure planned? □ No □ Yes ………….. If yes, when? ____/____/____

Do you have an upcoming event that you are planning for? □ No □ Yes ... If yes, when? ____/____/____

GOALS AND EXPECTATIONS

If there was something you could change or improve about your skin, what would it be?

____

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Is there anything else you would like us to know before we start your treatment plan?

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