Medical History

Name: ____ Age: _____________

Street: ____

City/Town: _________________________________ State: ______________ Zip Code: _______

Phone#: ___________________________________ Gender: ____ Male _____ Female

Email: ____ Date of Birth: ___________

Reason for consultation:

____ Acne ____ Flushing of the skin ____ Unwanted hair

____ Brown spots or sun damage ____ Skin Laxity ____ Fillers

____ Enlarged blood vessels ____ Rosacea ____ Botox

____ Skin Texture or Scars ____ Fine lines and Wrinkles ____ Hydrafacial

____ CoolSculpting & what areas? ____

Questions about Skin

1. What skin issues are you concerned about and how long have you been concerned about these skin issues
   ____
2. At what age did you notice this concern ____
3. Are your present skin concerns getting more pronounced? ____ Yes _____ No
4. Have you ever been treated for this concern? ____ Yes _____ No
   If yes when? ___________________________ What method? __________________
5. Are you currently taking medications for your skin concerns ____ Yes _____ No
   If yes, what is it? ____
6. What topical skin medications or products are you currently taking: ___ Retin-A _____Hydroquinone or bleaching agent Other _________________________________
7. Have you ever had laser/BBL/IPL hair removal? ____ Yes ____ No
8. Have you ever used the following hair removal methods in the past 6 weeks?
   ____ Shaving ___ Waxing ____ Electrolysis ____ Plucking/Tweezing ____Depilatories
9. Have you ever had skin resurfacing or rejuvenation or chemical peels?
10. Have you ever had treatments for pigmented lesions? ____ Yes ____ No
11. Do you form thick or raised scars (keloids) from cuts or burns? _____ Yes ____ No
12. Do you experience hyperpigmentation (redness) from burns, cuts, insect bites? ___ Yes ___No
13. Have you ever had cold sores or fever blisters? ____ Yes ____ No

Skin types choices when exposed to the sun for about 1 hour with no protection:

____ Always burn ____ Rarely burns _______ Always burns, sometimes tan

____ Brown, moderately pigmented _____ Sometimes burns, always tans ______ Black skin

1. When were you last exposed to the sun or tanning booth? ______________________________
2. Do you use self or sunless tanners? ____
3. Are you planning a vacation in the sun? ____

Personal History:

Do you smoke? _____ Yes ______ No

Do you consume alcohol daily _____ Yes ______ No If yes how much? ________________________

Do you wear contact lenses? _____ Yes _____ No

Medical history:

1. Are you currently under the care of a physician? _____ Yes _____ No

   If yes, what for: ____

2. Do you have any of the following?

   ____ Arthritis ____ Epilepsy or seizures ____ HIV/AIDS
   ____ Active infection ____ Heart Disease ____ MRSA
   ____ Bleeding disorder ____ Hepatitis ____ Sensitive teeth
   ____ Bruising ____ Herpes simplex ____ Skin cancer or moles
   ____ Dark spots of pregnancy ____ High blood pressure ____ Skin injury
   ____ Diabetes ____ Hormone imbalance ____ Vision deficits
   _____Melasma

   Other ____

3. Do you have allergies to any of the following:

   Food ________________________________ Plants __________________________________
   Anesthesia ___________________________
   Drugs & what was your reaction: ____
   ____

4. Do you take any of the following?

   ____ Accutane ____ Appetite depressants _____ Insulin
   ____ Antibiotics ____ Aspirin or Ibuprofen _____ Sedatives
   ____ Anti-coagulants ____ Cortisone or steroids _____ Thyroid medication
   ____ Anti-depressants ____ Hormone or contraceptives

   Other: ____

5. Are you taking herbal preparations or vitamins (St. John's Wort, Vitamin E, Fish oil)

   ____ Yes ____ No

6. Are you pregnant or trying to become pregnant? ____ Yes ____ No _____ N/A

   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 my current health conditions while seeking treatment as a client. I will update this information as it occurs.

   Signature: ____ Date: __________