Health Questionnaire
CONFIDENTIAL

Medical Information

Date of Birth ___/___/___ Age _____ Personal Physician _____ Physician phone _____

Do you smoke? ____ How much? _____ Live w/smoker? ____ Do you drink alcohol? ____ How often? _____

Do you have or have you ever been treated for: (please check all that apply)

- ❑ Depression
- ❑ Skin Disease/ Acne
- ❑ Diabetes
- ❑ Cancer
- ❑ Sinus
- ❑ Keloid/hypertrophic scarring
- ❑ Cold sores/Herpes
- ❑ Pacemaker
- ❑ Cancer/Melanoma
- ❑ Fainting spells or Seizures
- ❑ Auto-Immune Disorder/ Lupus/ Porphyria
- ❑ High Blood Pressure/Heart problems
- ❑ Paralysis/muscle weakness/ neurological problems
- ❑ Vitiligo

Explain _____

List all other past medical problems:

_____

List **ALL** medications you are currently taking (especially Accutane/ Isoretinion, blood thinners or any photosensitizing drugs): _____

_____

Are you pregnant? _____ Lactating? _____ Trying to get pregnant? ____

Are you on Hormone therapy / Birth Control? _____ Do you wear contact lenses? _____

Have you ever had an allergic reaction to: (please check all that apply)

- ❑ Cosmetics
- ❑ Aspirin
- ❑ Latex
- ❑ Glycolic acid
- ❑ Lactic acid
- ❑ Citric acid

List any and all other allergies: _____

Personal Information

Have you had cosmetic surgery? _____

How do you want to improve your skin? _____

What previous skin care treatments have you had? _____

What skin care are you currently using? _____

Client Name: _____

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Sun History and Lifestyle

Do you work inside or outside? _____

Do you use chemical sun tanning lotions? Y N If yes, when did you last use them _____

When was your last sun exposure? _____ Do you use tanning beds? _____

Are your hobbies done mostly inside or outside? _____

When exposed to the sun without protection for about 1 hour, how does your skin react?

- ❑ Burns always, never tans
- ❑ Burns always, something tans
- ❑ Burns, Tans, sometimes
- ❑ Tans always

Ethnic Background (please circle): Asian African American Caucasian European Hispanic Middle Eastern

Personal Interest

Please check all treatments/services that interest you:

- ❑ Professional skin care
- ❑ Botox®
- ❑ Temporary Fillers
- ❑ PDO Threads
- ❑ Microdermabrasion
- ❑ MicroLaser Peel
- ❑ IPL
- ❑ Hair Removal
- ❑ Skin Rejuvenation
- ❑ Wrinkle Reduction
- ❑ Treatment of Acne
- ❑ Treatment of Rosacea
- ❑ Treatment of Leg Veins
- ❑ Treatment of Melasma/other discolorations
- ❑ Enhancing and Defining Lips
- ❑ Biote Hormonal Therapy
- ❑ IV Nutritional Therapy
- ❑ Weight Management

How did you hear about our services? (please check which apply)

- ❑ Social Media
- ❑ Online / Internet:
  - ❑ CCMI Website
- ❑ Event hosted by CCMI
- ❑ Referred by Friend

Name: _____

Would you be interested in hearing about new services and products? ___ Yes ___ No

What is the best way to reach you? ____ E-mail ____ Cell Phone ____ Home Phone ____ Work Phone

Emergency Contact _____Telephone _____ Relationship_____

I certify that the information given is true to the best of my knowledge and certify that I will notify the office immediately if any changes occur in my medical history/health status.

Patient Signature _____ Date _____