Patient History Questionnaire

Patient Name: _____ Date: _____ D.O.B. _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ E-Mail: _____
Occupation: _____ Employer: _____ Wk. Phone: _____
Person to contact in case of emergency: _____
Reason for consultation: _____
Are you currently under a physicians care? _____ Specify: _____

HAVE YOU EVER HAD OR BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

	Yes	No		Yes	No		Yes	No
Heart Murmur	( )	( )	Do you smoke	( )	( )	Corneal Abrasions	( )	( )
Blepharoplasty	( )	( )	Circulatory problems	( )	( )	Phlebitis	( )	( )
Faint/Dizzy spells	( )	( )	Do you wear contacts	( )	( )	Skin Cancer	( )	( )
Keloids	( )	( )	Hyperpigmentation	( )	( )	Allergies	( )	( )
Thyroid Disease	( )	( )	High Blood Pressure	( )	( )	Diabetes	( )	( )
Herpes Simplex	( )	( )	Bleeding Disorder	( )	( )	Hepatitis	( )	( )
Tumors/Growths	( )	( )	Chemotherapy/Radiation	( )	( )	Asthma	( )	( )

List all medications you are currently taking:
List any drug, makeup, food, or skin allergies:
Have you been on Accutane in the past 9 months Laser resurfacing in the past year
Are you using, or have you ever used Retin-A Last application
Are you pregnant If pregnant, how far along are you
Have you ever been tested for HIV Results
Do you have an immune disorder that would impair your healing process
Are you prone to genital herpes breakouts Cold Sores
Do you have any Venereal Diseases If so, what are they
What is your natural haircolor Eye color
Have you recently undergone a skin peel If so, how long ago
Is your skin condition normal or abnormal
When did you last tan your skin Sun, tanning beds, creams
Have you ever had sclerotherapy If so, how long ago
When a scar appears on your skin, is it significantly dark in color
Are you currently taking birth control pills
Are you taking oral or injectable steroids If so, for what condition
Please circle your skin type: Oily Normal Dry Sensitive Combination
In your own words, describe your skin
What about your skin are you hoping to improve
Going back three generations, what is your family ancestry

Fitzpatrick Skin Test

Please circle the one that best describes your skin type:

Type I: Always burns, never tans. Red or blonde hair, light eyes.

Type II: Somewhat tans, mostly burns.

Type III: Sometimes burns, mostly tans, also known as olive complexion.

Type IV: Rarely burns, almost always tans, also known as olive complexion.

Type V: Moderately pigmented (Indian, Hispanic.)

Type VI: African American

MAJOR ALLERGIES:

	Yes	No		Yes	No
Milk	( )	( )	Papaya	( )	( )
Sugar/Beets	( )	( )	Apples	( )	( )
Retinoic acid	( )	( )	Pineapples	( )	( )
Aspirin	( )	( )	Citrus Fruits	( )	( )

PREVIOUS COSMETIC TREATMENTS:

	Yes	No		Yes	No
Acid Peel	( )	( )	Face Lift	( )	( )
Laser Surgery	( )	( )	Botox	( )	( )
Collagen	( )	( )	Microdermabrasion	( )	( )

Patient signature: _____ Date: _____

NAME _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ E-MAIL _____

CELL PHONE _____ WORK PHONE _____ D.O.B. _____

HOW DID YOU HEAR ABOUT US _____ REFERRED BY _____

Have you ever had any of the following conditions?
Check all that apply

_____ AIDS
_____ Anemia
_____ Arthritis Latex/Other:
_____ Auto Immune Deficiency
_____ Asthma
_____ Blood Transfusion
_____ Chemotherapy (active)
_____ Diabetes
_____ Dizziness
_____ Epilepsy
_____ Fainting
_____ Hay Fever
_____ Heart Disease
_____ Hepatitis
_____ High Blood Pressure
_____ Infection (active)
_____ Kidney Disease
_____ Liver Disease
_____ Lupus
_____ Melanoma
_____ Mental Disorder
_____ Nervous Disorder
_____ Radiation Treatment
_____ Respiratory Problems
_____ Skin Conditions
_____ Sinus Problems
_____ Stomach Problems
_____ Stroke
_____ Thyroid Problems
_____ Tuberculosis
_____ Ulcers
_____ Venereal Disease
_____ Other:

Allergies:

Cosmetics: _____

Latex/Other: _____

Have you ever/are you currently using:

Any retinoic acid product (Retin-A, Renova)	YES	NO
Prescription Acne	YES	NO
Birth Control Pills/Patch	YES	NO
Steroids	YES	NO
Are you pregnant?	YES	NO
Due Date: _____		
Are you lactating?	YES	NO

Previous Cosmetic Facial

Acid Peel	YES	NO	Date: _____
Botox	YES	NO	Date: _____
Collagen	YES	NO	Date: _____
Tattoo/Perm make-up	YES	NO	Date: _____
Waxing	YES	NO	Date: _____
Facial Surgery	YES	NO	Date: _____
Laser Surgery	YES	NO	Date: _____
Microdermabrasion	YES	NO	Date: _____

Have you ever had:

Cold Sore	YES	NO	
Fever Blister	YES	NO	
Frequency:	<1/yr	1-3/yr	4+/yr

List all current medications/supplements that you take:

_____

_____

_____

List any questions you have:

_____

_____

_____

EVALUATION:

Skin Type: _____ Normal _____ Oily _____ Dry _____ Combination _____ Other

Conditions: _____ Texture _____ Sun Damage _____ Acne/Oily
_____ Pigment Problems _____ Sensitive Skin Other: _____

Sunburn Sensitivity: _____ Always _____ Usually _____ Occasionally _____ Rarely _____ Never

Area of concern: _____