

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 _____

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	()	()

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

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: _____