Patient Information & Medical History

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

Patient Name: _____ Date: _____

Address: _____ City: _____ State: Zipcode: _____

DOB: ____ /____ / ____ Cell: _____ E-mail: _____

Please check box with the preferred way you would like to be notified of your appointment time
❑E-mail ❑Text Message - ***Cell phone provider*** (Verizon, AT&T, Etc.): _____

Emergency Contact Name: _____ Phone number _____

How were you referred to us? _____

MEDICAL HISTORY

Are you experiencing any health problems? ❑Yes ❑ No

If yes, what? _____

What oral medications are you currently using? (In the past 2-3 months)

Antibiotics Hormones Birth Control Diuretics Thyroid Blood Thinner

At any time in the present or past have you gotten cold sore or herpes? ❑YES ❑NO

SKIN HISTORY

Have you ever seen a dermatologist for your skin? ❑YES ❑NO

If yes when/why? _____

Have you ever had a skin allergy? ❑YES ❑NO

Do you have any known drug or food allergies? ❑YES ❑NO

If yes, to what drug or food? _____

In the past have you neglected to use sunblock? ❑YES ❑NO

Do you go to a tanning salon? ❑YES ❑NO

Do you have? ❑Birthmarks ❑Freckles ❑Redness ❑Pregnancy mask

Do you smoke? ❑YES ❑NO Do you consume alcohol? ❑YES ❑NO

Do you take vitamins/supplements? ❑YES ❑NO

How much water do you consume daily? _____ oz.

WOMEN ONLY

During pregnancy, did you hyperpigmentation or masking? ❑YES ❑NO
Are you taking oral contraception? ❑YES ❑NO
Are you trying to become Pregnant? ❑YES ❑NO
Are you pregnant or lactating? ❑YES ❑NO

Does your skin ever flake or feel tight & dry? ❑Frequently ❑Occasionally ❑Rarely

Is your skin ever shiny a few hours after cleansing? ❑Frequently ❑Occasionally ❑Rarely

How often do you experience blackheads or blemishes? ❑Frequently ❑Occasionally ❑Rarely

What skin type do you consider yourself to have? ❑Oily ❑Acneic ❑Dry
❑Mature ❑Combo ❑Normal

Does your skin appear sensitive? ❑YES ❑NO Do you form thick or raised scars? ❑YES ❑NO

Do you use sunscreen every day? ❑YES ❑NO
Have you had any enzyme or chemical peels? ❑YES ❑NO
Have you used Accutane? ❑YES ❑NO

What topical medications do you use or have used? _____

Retin-A Glycolic Acid Lactic Acid Salicylic Acid Other: _____

Have you ever had a laser procedure? ❑YES ❑NO
If yes, in what area? _____ How long ago? _____

Have you ever had facial plastic surgery? ❑YES ❑NO
If yes, in what area? _____ How long ago? _____

Have you ever had injectables? ❑Botox® ❑Dysport ❑Xeomin® ❑Juvéderm® ❑Radiesse®
❑Restylane® ❑Other: ❑NO

VASCULARITY

Broken Capillaries? ❑Nose ❑Cheeks ❑ Chin ❑Forehead ❑ Entire Face

Do you blush easily: ❑YES ❑NO
Have you been told you have Rosacea: ❑YES ❑NO

What amount of time do you spend in the sun in the summer? ❑ ½ hr. ❑1hr. ❑ 2hrs or more

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Patient Signature:_____ Date:_____

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