

**Patient Information**

Today's Date      ___/___/___		MRN#      _____
<b>Last Name</b>	<b>First Name</b>	<b>Middle Initial</b>
Marital Status	Age	Date of Birth ___/___/___
Address		
City	State	Zip Code
Home Phone (    )	Mobile (    )	Work (    )
Email Address	Preferred phone	
<i>Would you like to receive information on promotions &amp; events through email?</i> <i>yes</i> <i>no</i>		
Occupation:	Employer:	

**How did you hear about us?**

**Medical Health History**

Reason for visit:				
Have you had plastic surgery before? <i>yes</i> <i>no</i>				
If yes, type of surgery and when:				
Please list nutritional supplements and medications you are currently taking including hormone replacement therapy and birth control pills:				
Are you presently under a physician's care? <i>yes</i> <i>no</i> If yes, why?				
How is your general health? <i>Excellent</i> <i>Good</i> <i>Fair</i> <i>Poor</i>				
Do you exercise? <i>yes</i> <i>no</i>				
Smoker      Date quit smoking:      Never smoked				
Other nicotine products used:				
Do you drink alcohol? <i>yes</i> <i>no</i> If yes, type and how often:				
Have you ever used Accutane? <i>yes</i> <i>no</i> If yes when?				
Please check the following conditions you have currently or have experienced in the past:				
Abnormal Bleeding	Frequent Headaches	Seizures		
Anemia	Heart Disease	Stroke		
Asthma or COPD	Hepatitis	Thyroid disorder		
Cancer	High Blood Pressure			
Diabetes	High Cholesterol			
Other condition(s) not listed:				

<b>Allergies/sensitivities:</b>			
Latex	yes	no	
Lidocaine	yes	no	
Prescription drug	yes	no	Name of drug:
Anesthesia	yes	no	

Other allergies/sensitivities not listed:

Previous surgeries:

Date	Type of surgery	Surgeon / Facility

### Skin Care History

Have you seen a Dermatologist in the past year?      yes      no

If yes, list Dermatologist's name and reason for visit:

Please list any skin treatment(s) you are currently having:

Please check if you are presently using or have used in the past any of the following:

Hydrocortisone	Benzoyl Peroxide	Vitamin A	Resorcinol
Hydroquinone	Glycolic Acid (AHA)	Vitamin C	Salicylic Acid (BHA) Sulfur
	Lactic Acid (AHA)		

Please check if you have had any of the following in the last 14 days:

Waxing	Facial Cosmetic Surgery	Permanent Cosmetics	Microdermabrasion
Laser Hair Removal	Botox Injections		Light Treatments
	Collagen Injections		Laser Resurfacing
	Dermal Fillers		Chemical Exfoliation (Peel)

Please check if you are presently using or have used in the past any of the following **prescriptions**:

Tretinoin (Retin A, Retin -A Micro, Renova, Avita)	Tazarotene (Tazorac)	Triluma
	Isotretinoin (Accutane)	Metrogel
	Adepalene (Differin)	Azelaic Acid (Azelex, Finacea)

Any other topical antibiotic:

Please check if you presently have or have had in the past any of the following:

Skin Cancer	Acne	Treatment Reaction
Dermatitis	Rosacea	Hypopigmentation (skin lightening)
Keloid Scarring	Broken Capillaries	Hyperpigmentation (skin darkening)
Herpes Simplex or Cold Sores		

<b>Skin allergies/sensitivities:</b>			
Hydroquinone or skin bleaching agents	yes	no	
Hydrocortisone	yes	no	
Other skin allergies/sensitivities not listed:			
<b>Sun Protection</b>			
Do you use sunscreen?	yes	no	
Do you sunbathe?	yes	no	
Have you tanned in a tanning booth in the last 14 days?	yes	no	
Have you had any direct sun exposure in the last 14 days?	yes	no	
Have you recently used any self-tanning lotions or treatments?	yes	no	
When exposed to the sun do you:			
Always burn, never tan	Always burn, sometimes tan	Sometimes burn, sometimes tan	Always tan
Do you feel your skin is sensitive?	yes	no	
Do you tend to scar easily or form raised scars (keloids)?	yes	no	
<b><u>Hair Removal/Laser Treatment History</u></b>			
Have you ever had laser hair removal?	yes	no	
Please check any of the following hair removal methods used in the past six weeks:			
Shaving	Waxing	Electrolysis	Plucking      Tweezing      Stringing      Depilatories
Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma?	yes	no	
If yes, please describe:			
Please list any other necessary information your skin specialist should know before beginning your treatment:			
I have acknowledged that all the information provided by me is true and correct to the best of my knowledge. I understand that some skin conditions may require more than one treatment as well as use of home care products as directed to achieve the results desired. Results cannot be guaranteed due to individual skin type(s) and condition(s).			
I agree to inform the provider/staff of ANY changes pertaining to the above questionnaire prior to any future treatments. I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the esthetician, nurse or doctor of my current medical or health condition and to update this history now and in the future. A current medical history is essential for the caregiver to execute appropriate treatment procedures. I understand that payment is due at time of all services and products. There are NO REFUNDS on any services.			
<b>Client Signature:</b>		<b>Date:</b>	
_____		_____	