Health Questionnaire

Name	**Date of birth**
Address	**Occupation**
Town/City	
State Zip Code	
Please indicate your contact preference:	**Where did you live from birth to 20 years of age?**
Home phone:	What is your ethnic origin?
Work phone:	**How would you describe your skin?**
Cell phone:	□ I. Always burns, never tans, light colored hair and eyes
E-mail address:	□ II. Usually burns, tans with difficulty, light skin, blue or light colored eyes
Emergency Contact:	□ III. Sometimes burns but usually tans, eyes darker in color, slight color to skin
Relationship:	□ IV. Rarely burns, tans easily, dark eye coloring, definite dark color of skin
Home phone:	□ V. Very dark skin color, dark course hair, dark eyes (example: African American)
Cell phone:	

Primary Care Doctor:

What service(s) are you interested in?

Rank:	Concern:	Area:	How have you treated area in the past?
	Texture/Roughness		
	Red spots		
	Brown spots/Irregular skin tone		
	Fine lines/Deep wrinkles		
	Sagging/Loose skin		
	Pore size		
	Acne		
	Rosacea		
	Hair removal		

Are you taking medications that make you sensitive to the sun?
□ **Yes** □ **No**

Do you have any chronic skin conditions and/or have you suffered from hives, swelling or unusual skin coloration?
□ **Yes** □ **No**

Please list any medication allergies:

What oral or topical medication(s) do you take routinely or occasionally? (Please check all that apply)

□ Birth control pills	□ Accutane	**Current medicine?**
□ Gold	□ Cillins (penicillin family)	
□ St. John's Wort	□ Tetracycline	
□ Retinoids	□ Claritin	
□ Ibuprofen	□ Aspirin	
□ Creams/lotions:		

Health Questionnaire (cont'd)

Have you ever been treated with:	Area:	When:	Who/where:	Level of satisfaction
Botox				
Restylane or filler				
Laser facial or Laser treatment				
Micro dermabrasion				
Plastic surgery				
Other:				

Are you allergic to: (Please check all that apply)

- □ Aloe
- □ Latex
- □
- □
- □
- □

Do you have any of the following? (Please check all that apply)

- □ Contact lenses
- □ Hearing aides
- □ Metal pins or piercings
- □ Sensitive skin/wounds that do not heal

What other information should we know about your skin care treatments in the past?

Does your family have a history of: (Please check all that apply)

- □ Eczema
- □ Hay fever
- □ Allergies
- □ Melanoma
- □ Skin cancer (non-melanoma)

Do you or have you ever had: (Please check all that apply)

- □ Cold sores
- □ Genital herpes
- □ Convulsions or seizures
- □ Abnormal healing/bleeding/bruising
- □ Psychological or psychiatric problems
- □ Arthritis/joint pain
- □ Asthma/lung disease/shortness of breath
- □ Cancer (other than skin)
- □ Diabetes/thyroid problems
- □ Ear, eye, nose, throat or sinus problems
- □ Allergies/hayfever
- □ Eczema
- □ Heart trouble or murmur
- □ High or low blood pressure
- □ HIV and/or AIDS
- □ Impetigo (skin infections)
- □ Melanoma or non-melanoma (skin cancer)
- □ Melasma (mask of pregnancy)
- □ Problems with skin pigmentation
- □ Treatment with chemotherapy agents

Do you or have you: (Please check all that apply)

- □ Drink alcohol
- □ Smoke or chew tobacco
- □ Go to tanning salons
- □ Work outdoors
- □ Had x-ray treatments to your skin
- □ Had a reaction to a local anesthesia
- □ Had any organ transplants

Have you had any of the following: (Please check all that apply)

- □ Electrolysis
- □ Tweezing
- □ Laser
- □ Waxing

Women only: (Please check all that apply)

- □ Are you pregnant or nursing
- □ Do you have irregular periods

I have filled out this form to the best of my knowledge.
I have received a copy of the HIPPA policy.

Patient signature: ____________________

Date: ____________________