Patient Information

Date ____/_____/_____

Name (First)_____ (Last)_____ (MI)_____

Address_____

City_____ State_____ Zip_____

Email Address_____

Preferred Phone Number_____ Cell / Home May we leave a message? YES NO

Preferred method of communication from our office? (please circle all that apply) TEXT PHONE CALL EMAIL

Date of Birth _____/_____/_____ Age_____ Sex M / F Marital Status_____

Occupation_____ Employer_____

Emergency Contact Name_____

Relationship_____ Phone Number_____

How did you hear about us_____

Reason for consultation today_____

Please describe your skin and skin concerns by checking all that apply:

___ Thick	___ Dry	___ Active Acne	___ Sallow
___ Thin	___ Normal	___ Acne Scars/Scars	___ Puffiness
___ Saggy	___ Oily	___ Blackheads/Whiteheads	___ Rosacea
___ Firm	___ Combination	___ Cysts	___ Dehydrated
___ Fine lines	___ Large Pores	___ Dark spots/Patches	___ Eczema or Psoriasis
___ Wrinkled	___ Sun Freckles	___ Scaling/Flaking	___Dark Circles/Eyes
___ Aging	___ Uneven/Blotchy	___ Broken Capillaries	___ Other_____

Are there any other treatments/conditions you are interested in hearing more about? (please circle all that apply)

LONGER EYELASHES	DOUBLE CHIN
DARK SPOTS/HYPERPIGMENTATION	FINE LINES AND WRINKLES
EXCESSIVE SWEATING	SKIN LAXITY
THINNING HAIR	MEDICAL GRADE SKIN CARE
VAGINAL REJUVENATION	ACNE
SCAR TREATMENT	HAIR REMOVAL

Other_____

What is important to you when deciding on a treatment?_____

SKIN CARE

With what temperature water do you cleanse? ☐ Cool ☐ Warm ☐ Hot

Do you have any special skin problems pertaining to your face and body? ☐ Yes ☐ No

If yes, please specify _____

Do you experience irritation from shaving? ☐ Yes ☐ No Do you experience ingrown hairs? ☐ Yes☐ No

For unwanted hair do you ☐ wax, ☐ tweeze or ☐ have electrolysis?

Describe your current skin care

regimen:_____

_____

What brand name(s) to do you use?

_____

What spf sunscreen do you use on your face? _____ body? _____

Have you had any recent sun exposure in the past 4-6 weeks, including tanning beds, bronzing creams or spray tans?

If so, please specify_____

Are you using Retin-A, Hydroquinone (bleaching cream), glycolic acid, Accutane or any other medication that could cause sun sensitivity? ☐Y☐N

If yes, please explain_____

Social History

Do you follow a restricted diet? ☐Y☐N

Exercise Habits/Frequency_____

Cigarette smoke ☐Y☐N _____ packs per day _____ years

Alcohol use ☐Y☐N _____ drinks per _____

Drug use ☐Y☐N If yes, please explain_____

Do you have regular sleep patterns? ☐Y☐N

Do you consume caffeinated products? ☐ Yes ☐ No If yes, please explain_____

Please fill out as completely as you are able. All information will be held in strict confidence.

MEDICAL HISTORY

Name of Primary Care Provider_____ Office Phone_____

Illnesses (past five years): _____

Chronic or Current Conditions

Neurologic conditions: Y N Explain:_____

Cardiovascular conditions: Y N Explain:_____

Respiratory conditions: Y N Explain:_____

Endocrine disorders: Y N Explain:_____

Liver conditions: Y N Explain:_____

Kidney conditions: Y N Explain:_____

Autoimmune conditions: Y N Explain:_____

Infectious diseases: Y N Explain:_____

Coagulation disorders: Y N Explain:_____

Hereditary conditions: Y N Explain:_____

Connective tissue disorders: Y N Explain:_____

Cancers: Y N Explain:_____

Eye conditions: Y N Explain:_____

Skin conditions: Y N Explain:_____

Psychological conditions: Y N Explain:_____

Surgery, (incl. cosmetic): _____

_____

Do you faint easily? ☐Y☐N Do you scar easily? ☐Y☐N

Do you have any allergies? ☐Y☐N Explain:_____

Drug Therapy (please circle all that apply)

Please list any **prescribed** or **over the counter oral or topical medications** you are currently using, including: *allergy medications*, *acne treatments*, *Aspirin*, *Ibuprofen, herbs &* ***vitamins***:

_____

_____

Pharmacy Name_____ Phone Number_____

Have you ever seen a dermatologist? ☐Y☐N Any diagnosed condition(s)? ☐Y☐N

If yes, please explain_____

Dermatologist Name_____ Phone Number_____

Skin Care

Have you ever had a chemical peel? ☐Y☐N

Last treatment date:_____ Area treated_____

Have you recently had microdermabrasion? ☐Y☐N

Last treatment date:_____ Area treated_____

Have you ever had any laser or photofacial treatments in the past? ☐Y☐N

Last treatment date:_____ Area treated_____

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin), keloid scars or marks/scars from physical trauma, chicken pox or acne? ☐Y☐N

If so, please describe_____

Do you have any permanent cosmetic tattoos?

Last treatment date:_____ Area treated_____

Have you ever had Botox® or Dysport® injections?

Last treatment date:_____ Area treated_____

Have you had previous dermal filler, Kybella™or Sculptra® injections?

Last treatment date_____ Area treated_____

Frequent or occasional cold sores to mouth or genitalia?☐Y☐N

Do you wear contact lenses? ☐ Yes ☐ No

For women only:

Could you be pregnant? ☐Y☐N Are you breastfeeding? ☐Y☐N

Are your menstrual cycles normal? ☐Y☐N

Birth Control Pills? ☐Y☐N Depo-Provera ☐Y☐N Date of last shot? ___/___/_____

Menopausal/peri menopausal hormone replacement therapy? ☐Y☐N

Periodic acne flare-ups related to cycle? ☐Y☐N

Please sign below, and thank you for your time!

Patient Signature_____ Date____/____/_____

Provider Signature_____ Date____/____/_____

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