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SKIN HEALTH HISTORY INFORMATION

NAME: ______________________________ Today's Date: __________
Last First MI

Date of birth: ____________________ Age: ________ SEX: Male / Female

Primary Care Physician: ____________________ Phone number: ____________

Street address: ____

City: ______________________ State: ____________ Zip: __________

Referred by: ____

Unless otherwise indicated, we have permission to communicate changes in your health status, including surgery, to other physicians participating in your care. ☐ Yes, may notify ☐ No, please do not notify.

I. GENERAL

a. My skin type is best described by:

- ☐ I. Extremely fair skin, always burns, never tans
- ☐ II. Fair skin, always burns, sometimes tans
- ☐ III Medium skin, sometimes burns, always tans
- ☐ IV. Olive skin, rarely burns, always tans
- ☐ V. Moderately pigmented brown skin, never burn, always tans
- ☐ VI. Markedly pigmented black skin, never burns, always tans

b. Please indicate your current skin care products/regimen:

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Revised 8/21/08

II. MY SPECIFIC CONCERN(s) **and INTEREST**(s) **INCLUDE:**
(Please check all that apply and indicate any prior treatments.)

MY CONCERN(S)	√	LAST DATE AND TYPE OF ANY PRIOR TREATMENT(S) (e.g. Accutane/Botox/Peels/IPL/Lasers/Surgery/etc.)
Dry or Oily Skin		
Skin discoloration		
Brown Spots		
Acne		I have used Accutane: ☐ YES ☐ NO LastDose:____________
Rosacea		
Fine Wrinkles		
Deep Wrinkles		
Lip Lines		
Thin Lips		
Nasolabial Creases		
Marionette Lines		
Loose Skin		
Ageing Hands		
Excessive Sweating		
Facial/Body Hair		
Scars		
Facial Veins		
Leg Veins		
Not Certain		
Other		

b. Please list any dissatisfaction and/or complications from prior treatments or skin care products.

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III. PAST MEDICAL HISTORY:

a. What is your present: Height: ____________ Weight: _________

b. Could you be pregnant? ☐ Yes ☐ No

c. Are you nursing? ☐ Yes ☐ No

d. Please indicate if you have any history of the following:

HISTORY OF:	√	COMMENTS
Cold Sores/Shingles		
Skin Cancers		Please indicate type(s):
Easy Bruising		
Tattoos/Permanent Make-up		
Scleroderma		
Collagen Disorders		
Neurological Disorders		
Heart problems		
Hypertension		
Multiple Sclerosis		
Diabetes		
Eye Problems (eg. Dry eyes/Glaucoma/elevated intra-ocular pressure/Tearing/ itchy eyes/ pigment changes around eyes)		

IV. PAST SURGICAL HISTORY

Please list all prior surgical procedures. (This includes removal of tonsils/appendix/gallbladder/ LASIK surgery/wisdom tooth extraction/ mole excision/etc.)

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V. ANESTHETIC HISTORY

Have you ever had any problems with any of the following anesthetics? If so, please specify.

☐ Block (e.g. dental) Ineffective /Heart palpitations/Systemic reaction/Other ________________

☐ Local Ineffective/Heart palpitations/Systemic reaction/Other ________________

☐ Topical Ineffective/Heart palpitations/Systemic reaction/Other ________________

VI. MEDICATIONS

Please list ALL medications/vitamins/herbal supplements/ aspirin/ ibuprofen/NSAIDs.

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VII. ALLERGIES & SENSITIVITIES

a. Medication Allergies or Sensitivities? ☐**Yes** ☐**No**
If so, please indicate drug.

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____

b. Please list any products that irritate your skin:

____

____

c. Environmental or Food Allergies? ☐**Yes** ☐**No**

d. Latex Allergies? ☐**Yes** ☐**No**

VIII. SOCIAL HISTORY

a. Do you or have you ever smoked? ☐**Yes** ☐**No**
If yes, please indicate and circle appropriate reply:

_______ Cig's or Packs/Day _______ x Years Quit ______ weeks/months/years ago

b. Do you drink alcohol? ____ times/Day ____ times/Week ____ Rarely _____ Never

IX. MISCELLANEOUS

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SIGNATURE: ____