



Medical History for Skin Procedures

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Phone #1 _____ Phone #2 _____

Female Male DOB: ___/___/___

Referred by _____ Email Address _____

Reason for Consultation

<input type="checkbox"/> Acne	<input type="checkbox"/> Flushing of the Skin
<input type="checkbox"/> Brown spots or sun damage	<input type="checkbox"/> Skin laxity
<input type="checkbox"/> Enlarged blood vessels	<input type="checkbox"/> Skin texture or scars
<input type="checkbox"/> Fine lines or wrinkles	<input type="checkbox"/> Unwanted hair

Questions About Skin

1. How long have you been concerned about this area(s)? _____

2. At what age did you notice this concern(s)? _____

3. Are your present skin concern(s) getting more pronounced? Yes No

4. Have you ever been treated for this concern(s)? Yes No

If yes, when? _____

What method? _____

5. Are you currently taking medication for your skin's concern(s)? Yes No

If yes, what is it? _____

6. What topical skin medications or products are you currently taking? _____





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Retin-A® Hydroquinone or bleaching agent Other

7. Have you ever had laser / IPL hair removal? Yes No

8. Have you ever used the following hair removal methods in the past 6 weeks?

shaving waxing electrolysis plucking/tweezing stringing depilatories

9. Have you ever had skin resurfacing or rejuvenation or chemical peels? Yes No

10. Have you ever had treatments for pigmented lesions? Yes No

11. Do you form thick or raised scars (keloids) from cut or burns? Yes No

12. Do you experience hyperpigmentation (redness) from burns, cuts, insect bites? Yes No

13. Have you had cold sores or fever blisters? Yes No

Skin Type Choices (when exposed to the sun for about 1 hour with no protection):

Always burns, never tans

Rarely, burns, always tans

Always burns, sometimes tans

Brown, moderately pigmented skin

Sometimes burns, always tans

Black skin

When were you last exposed to the sun or tanning booth? _____

1. Do you use self tanners? Yes No

2. Are you planning a vacation in the sun? Yes No

Personal History:

1. Do you smoke? Yes No If yes _____ packs per day

2. What is your daily consumption of alcohol? _____

3. Do you wear contact lenses? Yes No





Medical History:

1. Are you currently under the care of a physician? Yes No

If yes, for what: _____

2. Do you have any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Dark spots of pregnancy |
| <input type="checkbox"/> Any active infection | <input type="checkbox"/> Bruising | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> HIV / Aids | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Sensitive teeth | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Skin cancer or moles |
| <input type="checkbox"/> Herpes simplex | <input type="checkbox"/> Skin injury | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Vision deficits | <input type="checkbox"/> Hormone imbalance | <input type="checkbox"/> Other _____ |

3. Do you have allergies to any of the following? (check all that apply)

medications latex plants anesthesia other _____

4. Do you take any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Accutane | <input type="checkbox"/> Appetite depressants | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Aspirin or Ibuprofen | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Anti-coagulants | <input type="checkbox"/> Cortisone or steroids | <input type="checkbox"/> Thyroid medication |
| <input type="checkbox"/> Anti-depressants | <input type="checkbox"/> Hormone/contraceptives | <input type="checkbox"/> Other _____ |

5. Are you taking herbal preparations or vitamins? (St. John's Wort, Vitamin E) Yes No

For Female Patients:

1. Are you pregnant or trying to become pregnant? Yes No

I have answered the questions contained in this questionnaire to the best of my knowledge. I understand that it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this information as it occurs.

Signature _____ Date _____

