Patient Profile – Medical History

Name: _____ Sex: ____ Age: _____ Date of Birth: _____

Address: _____ Daytime Phone: _____

City: _____ State: _____ Zip: _____ Cell/Alt. Phone: _____

1. **Have you ever had or have been treated for**: **("X" all that apply)**

☐ AIDS/ARC	☐ allergy/hay fever	☐ dizziness/fainting spells	☐ epilepsy
☐ skin rash/disease	☐ asthma or wheezing	☐ head injury	☐ eye injury or disease
☐ heart trouble	☐ shortness of breath	☐ neuritis (nerve inflammation)	☐ swollen/painful joints
☐ cancer	☐ tuberculosis	☐ mitral valve prolapse	☐ rheumatism/arthritis
☐ diabetes	☐ varicose veins	☐ drug or alcohol addiction	☐ tendonitis
☐ high blood pressure	☐ phlebitis of vein	☐ frequent severe headaches	☐ bone or joint deformity
☐ bleeding problems	☐ back problem/pain	☐ nervousness	☐ ankle/feet swelling

2. **List any other diseases or illnesses you have had**:

_____

_____

3. **List all prescription and non-prescription medication you are currently taking or have recently taken**:

☐ Heart ☐ Thyroid ☐ Blood Pressure ☐ Vitamins ☐ Tazorac
☐ Cold/Allergy preparations ☐ Insulin/other diabetic mediations
☐ Tranquilizers/Anti-depressants ☐ Herbal/Nutritional supplements
☐ Retin-A/Renova/Differin/Hydroquinone ☐ Testosterone/estrogen
☐ Antibodies ☐ Accutane – when stopped: _____

List others: _____

_____

_____

4. **List below all hospitalizations for illness, operations, accidents or fractures**:

Year: _____ Hospital: _____
Reason: _____
Year: _____ Hospital: _____
Reason: _____
Year: _____ Hospital: _____
Reason: _____

5 **Do you drink alcohol?**

☐ No
☐ 1-2 drinks per week
☐ 3-5 drinks per week
☐ 5+ drinks per week

Do you smoke?

☐ No
☐ Less than 1 pack per day
☐ 1 pack per day
☐ More than 1 pack per day

6. **Family Physician**: **(Name and Telephone)**

_____

Date of Last Physical? _____

7. **When you go to the dentist**:

Do they give you antibiotics before the procedure? Yes No
Do you require extra numbing medication? Yes No

8. **Pharmacy Telephone**: _____

9. **WOMEN ONLY**:

Date of your last menstrual period _____
Do you have problems with your period? _____
Are you pregnant? _____ Due Date: _____

10. **Additional Questions**:

Do you wear contacts (you may need to remove them)? Yes No

11. **Previous Cosmetic Procedures**:

Do you currently get facial/waxing/electrolysis/or use depilatories? _____ When and what kind? _____
Are you currently having microdermabrasion performed? _____ When and what kind? _____
Have you recently had laser resurfacing? _____ Depth? _____ When and what kind? _____
Have you had a collagen/dermal filler injection(s)? _____ When and what kind? _____
Have you had a Botox injection(s)? _____ When? _____ Describe your reaction: _____
Have you ever had a peel? _____ When and what kind? _____ Describe your reaction: _____
Have you recently had facial or cosmetic surgery? _____ When and what kind? _____
Describe: _____

12. **Allergies**:

List all other allergies to medication _____
Are you allergic/sensitive to? (check all that apply) ☐ Lidocane ☐ Adhesive Tape ☐ Latex ☐ Hydroquinone ☐ Aloe vera ☐ Aspirin
☐ Perfumes ☐ Citrus ☐ Grapes ☐ Mushrooms ☐ Milk ☐ Apples ☐ Alcohol based products? _____
Have you every used any products that caused a bad reaction? _____ Describe: _____
Have you ever seen a dermatologist or other physician for your skin? _____ If yes, why? _____
Have you ever had a skin allergy or sensitivity? (Rash, irritation, peeling, swelling, hives, etc.)? _____ If yes, explain: _____

13. **Skin Description**:

Tell me about your skin; describe if for me: ☐ Thick ☐ Thin ☐ Saggy ☐ Firm ☐ Normal ☐ Dry ☐ T-zone/Combination
☐ Oily ☐ Acne ☐ Comedones ☐ Milia ☐ Cysts ☐ Breakout ☐ Acne scarred ☐ Large pores ☐ Small pores
☐ Florid ☐ Rosacea ☐ Eczema ☐ Freckled ☐ Sun-damaged ☐ Uneven/blotchy ☐ Mature ☐ Wrinkled ☐ Psoriasis
☐ Patchy dryness on _____ ☐ Sallow ☐ Melasma ☐ Perfume-stained ☐ Hypo-pigmented (lack of pigment)
☐ Hyper-pigmented (excess pigment) ☐ Dehydrated (lack of moisture) ☐ Telangiectasia/broken surface capillaries.

Do you consider yourself: ☐ Sensitive ☐ Resilient ☐ Not Sure

Skin tone: ☐ Pale/White ☐ Light ☐ Medium ☐ Reddish ☐ Freckled ☐ Lt. Olive ☐ Med. Olive ☐ Dark Olive ☐ Lt. Brown
☐ Med. Brown ☐ Dark Brown ☐ Soft Black ☐ Black ☐ Sallow

Do you "flush" or appear redden easily when you eat spicy food, drink alcohol, get angry, go in the sun, etc.? _____

What is your hereditary makeup?_____

Pigmentation (FITZPATRICK SCALE): How do you tan?

☐ I Burn ☐ II Usually Burn ☐ III Sometimes Burn ☐ IV Rarely Burn ☐ V Never Burn ☐ VI Never Burn Black

Pigmentation: ☐ Even ☐ Uneven

Vascurality: (telangiectasia or broken capillaries):

☐ Nose area ☐ Cheek area ☐ Chin area ☐ Forehead ☐ Entire Face

Acne: Do you have a history of acne or periodic breakouts?

☐ Pimples ☐ Whiteheads ☐ Blackheads ☐ Enlarged Pores ☐ Acne Scars ☐ Cysts ☐ Flakiness

Skin Type:

Does your skin every flake or feel tight and dry?	☐ Frequently	☐ Occasionally	☐ Rarely
Is your skin ever shiny a few hours after cleansing?	☐ Frequently	☐ Occasionally	☐ Rarely
How often do you experience breakouts?	☐ Frequently	☐ Occasionally	☐ Rarely
How noticeable are your pores?	☐ Very	☐ T-Zone	☐ Not very

Ability to Heal:

Does your skin appear fragile or burn easily? _____ If yes, explain: _____

Do you have any problems healing from a cut or burn? _____ If yes, explain: _____

Have you ever had a "cold sore"? _____ If yes, explain: _____

Sun History and Lifestyle:

Do you work primarily inside? __ Occupation: _____

Are your hobbies done mostly outside? _____ Hobbies: _____

In the past have you neglected to use sunscreen? _____ If yes, explain: _____

Are you in the habit of going to tanning booths? _____

Do you currently use sun block regularly? _____

Are you currently sunburn/windburn/red faced? _____

What is your daily home care regimen? _____

HAVE YOU OR ANYONE IN YOUR FAMILY HAD SKIN CANCER? _____ If yes, explain: _____

_____

14. **Desired improvements**:

What specific areas do you want to treat?

☐ Face ☐ Neck ☐ Chest ☐ Back ☐ Legs/Bikini ☐ Other _____

What are the cosmetic improvements you would like to see in your skin? _____

_____

_____

_____

_____

_____ _____

Patient Signature Date Clinician Signature Date

This is a confidential report of your medical history and will be kept in this office. Information contained herein will not be released to any person or organizations except when you have authorized us to do so.