HEALTH HISTORY

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: _____

Email: _____

Date of birth: _____ Age: _____

Insurance: _____

What is your hereditary/Ethnic background?

_____

How would you describe your skin? (Please check ALL that apply)

__ Oily __ Sensitive __ Dry __ Normal __ Combination

Have you received ANY of the following procedures?

__ Chemical Peels __ Facial Ultrasound __ Eye Lash/Brow tint

__ Facial __ Microneedling __ Dermaplaning

__ Waxing __ Laser Hair Removal __ Botox

__ Fillers __ Microdermabrasion __ PRP

__ Light therapy __ Other _____

If yes, please explain: _____

_____

Have you used ANY of the following topical/oral medications?

___ Accutane ___ Differin ___ Retin-A ___ Avage

___ Renova ___ Tazarac ___ Tretinoin ___ EpiDuo

___ Hydroquinone ___ Topical Antibiotics ___ Ziana

___ Alpha Hydroxy Acids ___ Coumadin ___ Other _____

Please list Current medications, herbal supplements and vitamins.

Please include birth control, diuretics, slimming pills, and OTC medications

_____

ALLERGIES: _____

LIFESTYLE

How much water do you consume daily? _____

How much caffeine do you consume daily? _____

Do you smoke? Yes__ No__

Do you exercise regularly? Yes__ No__

Do you follow a restricted diet? Yes__ No__

Do you suffer from sinus problems? Yes__ No__

Do you sunbathe or use tanning beds? Yes__ No__

Do you have an intolerance to heat or cold? Yes__ No__

Do you burn easily or have a tendency to redness? Yes__ No__

Do you ever experience obvious tightness, dryness or flaking on your skin? Yes__ No__

Do you ever experience burning, itching, or stinging sensation on your skin? Yes__ No__

Do you have a history of easy or excessive hyperpigmentation? Yes __ No__

Do you wear contact lenses? Yes__ No__

Have you had your annual skin cancer exam? Yes__ No__

Rate your level of stress on a scale of 1 to 5 (1= low, 5=high): ____

FEMALE

Are you using ANY form of contraception? Yes__ No__

Are you pregnant or trying to become pregnant? Yes__ No__

Are you lactating? Yes__ No__

Are you currently having/due for your menstrual cycle? Yes__No__

MEDICAL HISTORY

Have you ever had ANY of the following conditions?

Acne	Yes __ No __
Arthritis	Yes __ No __
Diabetes	Yes __ No __
Severe Headaches/Migraine	Yes __ No __
Cold Sore/Fever Blisters	Yes __ No __
Shingles	Yes __ No __
Seizures	Yes __ No __
Cancer	Yes __ No __
Heart Conditions	Yes __ No __
Pacemaker/Metal Implants	Yes __ No __
Hepatitis	Yes __ No __
Skin Disorder (i.e. Dermatitis)	Yes __ No __
Collagen Disorder	Yes __ No __
Hypertrophic Scaring (i.e. keloid)	Yes __ No __
Bleeding Disorder (i.e. Anemia)	Yes __ No __
HIV/AIDS	Yes __ No __
Thyroid Disease	Yes __ No __
Lupus	Yes __ No __
Active Infection	Yes __ No __
Recent Surgery	Yes __ No __

What are your specific concerns/challenges with your skin?

_____

_____

_____

_____

_____

PLEASE LIST ALL CURRENT SKINCARE PRODUCTS

FACE

AM:

_____

_____

_____

PM: _____

_____

BODY

_____

_____

_____

UPCOMING EVENTS

_____

RECOMMENDATION OF PRODUCTS/TREATMENTS

_____

_____

_____

_____

AGREEMENT

Do you understand that every procedure has a period of healing before the tissue returns to normal and the result is apparent? Yes __ No __

Do you understand that the objective of ANY cosmetic procedure is an improvement NOT perfection? Yes __ No __

Have I been clear and complete with answering ALL of your questions? Yes __ No __

I agree to wear SPF 30+ daily Yes__ No__

I confirm, to the best of my knowledge, that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment or further future treatments. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I consent to the taking of photographs to monitor treatment effects, as desired or recommended by the provider.

My expectations are realistic and I understand that the results are not a guaranteed. I am willing to follow recommendations made by the provider for a home care regimen that can minimize or eliminate possible negative reactions and/or help me achieve the best results possible.

Should I have additional questions or concerns regarding my treatment or suggested home products/post-treatment care, I will consult the provider immediately. The treatments I receive here are voluntary and I release this institution and/or professional provider from liability and assume full responsibility thereof.

Date: _____

Patient Name: _____

Patient/Guardian Signature: _____

Skin Care Provider Signature:

_____