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Health History

Personal information

Date: _____

Last name: _____ First: _____ M.I.: _____

Street address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____

Cell: _____ Email: _____

Date of Birth (month/day/year): _____ Age: _____ Sex: Female Male

Where did you hear about us: (please be specific)

Internet: _____ Referral: _____

Advertisement: _____ if so where: _____ Other: _____

I am interested in: (please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Botox | <input type="checkbox"/> Sun damage | <input type="checkbox"/> Skin care advice/products |
| <input type="checkbox"/> Fillers | <input type="checkbox"/> Cellulite reduction | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Rosacea | <input type="checkbox"/> Skin tightening | <input type="checkbox"/> Facial/leg vein treatments |
| <input type="checkbox"/> Acne treatments | <input type="checkbox"/> Fat reduction | <input type="checkbox"/> Hair removal |
| <input type="checkbox"/> Fine lines/wrinkles | <input type="checkbox"/> Tattoo removal | <input type="checkbox"/> Vaginal rejuvenation |
| <input type="checkbox"/> Other, please specify _____ | | |

Do you use sunscreen? Yes, if yes spf # _____ No

When you sunbathe, how does your skin respond?

- | | | |
|---|--|--|
| <input type="checkbox"/> Always burn, never tan | <input type="checkbox"/> Usually burn, tan with difficulty | <input type="checkbox"/> Sometimes burn, tan about average |
| <input type="checkbox"/> Almost never burn, tan very easily | <input type="checkbox"/> Rarely burn, tan easily | <input type="checkbox"/> Never burn, always tan |

Medical history: (check the appropriate box next to any condition for which you have ever been treated)

- | | | |
|---|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Hirsutism | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Vitiligo | <input type="checkbox"/> Skin pigmentation |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Steroid or hormonal therapy |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Hormonal imbalances |
| <input type="checkbox"/> Cancer (or radiation therapy) | <input type="checkbox"/> Port wine stain | <input type="checkbox"/> Polycystic ovarian syndrome |
| <input type="checkbox"/> Diabetes / diabetic neuropathy | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Keloid scars / other scars |
| <input type="checkbox"/> Herpes (or cold sores) | <input type="checkbox"/> Pacemaker | |

Additional questions:

1 Are you currently being treated for any conditions not listed? If yes, please specify.

2 Are you currently taking any medications, including herbal preparations, medical patches or asa? If yes, please specify.

3 Do you have any allergies? If yes, please specify.

4 Have you ever used (or are currently using) retin a or glycolic acid? If yes, please specify.

5 Have you ever used (or are currently using) accutane? If yes, please specify.

6 Have you ever had a chemical peel? If yes, please specify.

7 Have you had any laser treatments? If yes, please specify.

8 What products are you currently using on your skin?

9 Do you have any dental or acrylic implants, crowns or bridgework? If yes, please specify.

10 Do you have any tattoos or permanent makeup in the area to be treated?
If yes, please specify.

11 Do you have a pacemaker?

12 Have you ever been treated by an endocrinologist (hormone imbalance)?
If yes, please specify.

13 Do you sunbathe or use self-tanning lotions or use tanning beds? If so, then how often?

14 Have you ever had gold therapy (used for rheumatoid arthritis)?

15 Are you currently pregnant?

16 Have you had filler or botox/dysport injections in the area to be treated?
If yes, please specify.

17 Do you have any particular skin sensitivities?

Please sign below to indicate all the information on this form is accurate and complete.

Signature: _____ Date: _____