



Medical Questionnaire

Name _____ Date _____ Date of Birth _____

Do you have or have you ever had any of the following?

Yes No

- Skin Cancer / Melanoma
- Acne
- Cold sores
- Keloids / Bad scars
- Eczema / Skin rashes
- Difficulty with wound healing
- Difficulty with skin infections
- Psoriasis
- Asthma / Hay fever / Hives / Sinus problems
- Rheumatic Fever
- Heart Disease
- High blood pressure
- Heart murmur / Mitral Valve Prolapse
- Artificial joint, heart valve, or prosthesis
- Heart burn / Ulcers / Gastritis / Reflux
- Kidney Disease
- Glaucoma
- Diabetes
- Tuberculosis
- Blood-bourne Infections
- Autoimmune disease (Lupus, rheumatoid arthritis)
- Blood transfusions
Dates: _____
- Hepatitis – B or C (please circle)
- HIV
- Surgery/hospitalizations
Operation _____ Date _____ Hospital _____
- Other _____

Have any blood relatives ever had any of the following?

- Skin Cancer
- Melanoma
- Abnormal moles
- Asthma / Hay fever
- Eczema / Skin rashes
- Diabetes
- Psoriasis
- Other skin disease _____

Signature: _____

Are you allergic to any medications?

(Please list) If none, check here

Are you currently taking or using any medications or vitamin / mineral supplements?

(Please list) If none, check here

Other Questions

Yes No

Are you currently taking Accutane or have you used Accutane in the past?

Are you in good health?

Are you now under a physician's care?
If so, for what conditions?

Name of your primary care physician

- | | Yes | No |
|--|--------------------------|--------------------------|
| Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you drink? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you sunbathe or use tanning booths? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you need antibiotics before surgery or dental work? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you bleed easily for a long time after a cut or extraction? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use sunscreen? | <input type="checkbox"/> | <input type="checkbox"/> |

Females only

Are you pregnant?

Are you nursing?

Do you take birth control pills?

Name of birth control pills _____

Date of last menstrual period ____/____/____

DATE PROVIDER REVIEWED:	PROVIDER INITIALS:
_____	_____
_____	_____
_____	_____



Aesthetic Skin Health History

Name _____ Age _____ Date ____ / ____ / ____ Office _____

How did you hear about us? MD Referral Family/Friend Magazine Yellow Pages Postcard Other _____

What are your main concerns about the appearance of your skin?

Red Spots Brown Spots Rosacea Fine Wrinkles Deep Wrinkles Sun Damage Tone & Texture Acne

Enlarged Pores Oily Spots Dry Skin Scarring Facial Veins Leg Veins Unwanted Hair Other _____

Please list skin care products used: (brand, how often)

Cleanser

Toner

Rejuvenation

Moisturizer

Sunblock

Make Up

Self Tanner

Bleaching Agent

Any known skin allergies? (cosmetics, sunblock, etc.)

Have you ever had any skin care procedures? (facials, peels, lasers, etc.)

Have you ever had any injectable procedures (Botox, collagen, etc.)

Have you ever had permanent make up applied? Y N What area(s)? _____

What skin care products/procedures are you interested in?

Office Use Only

Patient Signature: _____ Date: ____ / ____ / ____

Reviewed By: _____ Date: ____ / ____ / ____

M.D. Signature: _____ Date: ____ / ____ / ____