

Patient History Questionnaire

Date: _____ Patient Name: _____ Date of Birth: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ E-Mail: _____
 Employer: _____ Occupation: _____ Work Phone: _____
 Person to contact in case of emergency: _____
 Reason for consultation: _____
 Are you currently under a physicians care? _____ Specify: _____

<u>HAVE YOU EVER BEEN DIAGNOSED WITH</u>								
	Yes	No		Yes	No		Yes	No
Diabetes	()	()	Heart Murmur	()	()	Phlebitis	()	()
Keloids	()	()	High Blood Pressure	()	()	Allergies	()	()
Thyroid disease	()	()	Bleeding Disorder	()	()	Hepatitis	()	()

<u>DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS</u>					
	Yes	No		Yes	No
Herpes Simplex	()	()	Chemotherapy/Radiation	()	()
Smoke	()	()	Corneal Abrasions	()	()
Eye Lid injury	()	()	Blepharoplasty	()	()
Do you wear contacts	()	()	Tumors/Growths	()	()
Skin Cancer	()	()	Hyperpigmentation	()	()
Fainting/Dizzy spells	()	()	Circulatory problems	()	()

List all medications you are currently taking: _____

List any drug, make-up, food, and skin allergies: _____

Have you been on accutane in the past in the past nine months? _____ Laser resurfacing in the past year? _____

Are you, or have you ever used Retin-A? _____

Are you pregnant? _____ If so, how far along are you? _____

Have you ever been tested for HIV? _____ Results? _____

Do you have an immune disorder that would impair your healing process? _____

Are you prone to genital herpes breakouts? _____ Cold Sores? _____

Do you have any Venereal Diseases? _____ If so, what are they? _____

What is your natural hair color? _____ Eye color? _____

Have you recently undergone a skin peel? _____ If so, how long ago? _____

Is your skin condition normal or abnormal? _____

When did you last tan your skin? _____ Sun, tanning beds, creams? _____

Have you ever had sclerotherapy? _____ If so, how long ago? _____

When a scar appears on your skin, is it significantly dark in color? _____

Are you currently taking birth control pills? _____

Are you taking oral or injectable steroids? _____ If so, for what condition? _____

Is your skin type: Oily Normal Dry Sensitive Combination (Please circle)

<u>Previous Cosmetic Treatments</u>					
	Yes	No		Yes	No
Acid Peel	()	()	Face Lift	()	()
Laser Surgery	()	()	Botox	()	()
Collagen	()	()	Microdermabrasion	()	()

<u>MAJOR ALLERGIES</u>					
	Yes	No		Yes	No
Milk	()	()	Grapes	()	()
Sugar/Beets	()	()	Apples	()	()
Retinoic acid	()	()	Tomatoes	()	()
Asprin	()	()	Citric fruits	()	()

In your own words, describe your skin: _____

What are you hoping to improve with your skin? _____

Going back three generations, what is your family ancestry? _____

Patient signature: _____ Date: _____

Fitzpatrick Skin Test

Please circle the one that describes your skin type:

Type I- Always burns, never tans. Red or blonde hair, light eyes.

Type II- Somewhat tans, mostly burns.

Type III- Sometimes burns, mostly tans, also known as "olive" complexion.

Type IV- Rarely burns, almost always tans, also known as "olive" complexion.

Type V- Moderately pigmented, (Indian, Hispanic, ect)

Type VI- African American