PATIENT INFORMATION FORM
Medical History & Skin Evaluation

Patient Name _____ Date _____

Mailing Address _____

City _____ State _____ Zip Code _____

Telephone: Home _____ Work _____ Cell/Pager _____

Email address: _____Employer _____ Occupation _____

Date of Birth _____ Gender ☐ F ☐ M

Marital Status ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Other _____

Spouse's Name _____ Work Phone _____

Parents' Names (if child) _____Work Phone _____

Pharmacy _____ Phone_____ Address_____

How did you hear about our office? _____

Please circle all that apply:

Do you smoke? Yes/No

Have you had cosmetic surgery? Yes/No If yes, when? _____

Describe Procedure(s): _____

Have you ever had: Botox Yes/No Juvederm Yes/No Other injections: _____

Are you under the care of a physician? Yes No Please describe: _____

Do you have any allergies? Yes/No If yes, please explain: _____

Do you Suntan? Yes/No If yes, how often? _____

Do you use sunscreen? Yes/No

History of Health Conditions: (Please circle)

Bleeding	Yes/No	Skin Cancer	Yes/No
Stomach Ulcers	Yes/No	High Blood Pressure	Yes/No
Hives	Yes/No	Tuberculosis	Yes/No
Heart Murmur	Yes/No	Pacemaker	Yes/No
Eczema	Yes/No	Psoriasis	Yes/No
Asthma	Yes/No	Hay Fever	Yes/No
Hepatitis	Yes/No	HIV	Yes/No
Epilepsy	Yes/No	Diabetes	Yes/No
Hypoglycemia	Yes/No	Thyroid Disorder	Yes/No
Phlebitis	Yes/No	Dermatitis	Yes/No

Other: _____

Skin Condition: (Please circle)

How would you characterize your skin? Dry Sensitive Normal Combination Oily Acne Prone

Have you ever had: Herpes Cold Sores Fever Blisters Keloids Warts Milia

Skin Allergies and Sensitivities: Sulfa Anesthetic Latex Cosmetics Other _____

What topical prescriptions do you use: Retin-A TriLuma Antibiotics Other _____

What oral prescriptions do you use? _____

What over the counter medicines/supplements do you use? _____

What topical skin care products do you use:

Cleanser Brand _____ Toner _____ Day Moisturizer _____

Night Moisturizer _____ Scrub _____ Mask _____

Eye Cream _____ Sunscreen _____ Serum _____

Other _____

Men Only:

Do you ever experience irritation from shaving? Yes/No Do you experience ingrown hairs? Yes/No

How often do you shave? _____ What type of shaver do you use? Electric Hand-held

Women Only:

Do you wear make-up? Yes/No Do you menstruate? Yes/No Are you pregnant? Yes/No

Are you breast-feeding? Yes/No Do you take birth control pills? Yes/No

Have you had any of the following in the past year?

Skin Cancer	Yes/No	Waxing	Yes/No	Use of Accutane	Yes/No
Skin Infections	Yes/No	Tanning Bed	Yes/No	Facial Waxing or Depilatory	Yes/No
Laser Skin Resurfacing	Yes/No	Chemical Peel	Yes/No	Photo Sensitizing Substances	Yes/No
Laser work of any type	Yes/No	Electrolysis	Yes/No		

How much water do you consume daily? 1-2cups 3-4cups 5-6cups 7-8cups 9+ daily

Please list any concerns about your skin you would like to address:

_____

_____

Our office has a 24 hour cancellation policy. To avoid a $25 charge, please give at least 24 hours notice via phone if you need to change your appointment. (Initial) _____

Patient Signature _____ Date _____