Medical & Aesthetic History

Are you under the care of a Dermatologist?  Yes ☐  No ☐
Dermatologists Name: ____________________ Reason for Treatment: ____________________

Do you take any over the counter medications (including Dietary Supplements, Vitamins, Herbal Supplements, Aspirin, etc.) regularly?  Yes ☐  No ☐
If Yes, Please Describe: __________________________________________________________
______________________________________________________________________________

List any medications you take regularly: _____________________________________________
______________________________________________________________________________

Do you smoke?  Yes ☐  No ☐
Do you wear contact lenses?  Yes ☐  No ☐
Do you have any metal implants or wear a pacemaker?  Yes ☐  No ☐
What is your stress level?  High ☐  Medium ☐  Low ☐
Do you have any problems with Anesthesia?  Yes ☐  No ☐
Do you have any problems with Bleeding?  Yes ☐  No ☐

For Women

Are you Pregnant: Yes ☐  No ☐  Due Date: __________
Are you trying to become Pregnant? _______ Yes ☐  No ☐  Are you Lactating? Yes ☐  No ☐
Are you on Oral Contraceptives? Yes ☐  No ☐
Any recent changes to your contraceptive treatment? Yes ☐  No ☐
If yes, what and when? __________________________________________________________
Any menopause problems? Yes ☐  No ☐
If yes, please specify: __________________________________________________________

Do you have any of the following:

☐ Any Active Infection ☐ Immune Disorders
☐ Diabetes ☐ Seizure Disorder
☐ Fever Blisters/Cold Sores ☐ Eczema or Psoriasis
☐ (Last Episode:_______) ☐ Thyroid Condition
☐ Hepatitis
Skin Conditions or Concerns:

- Acne
- Facial Veins/Capillaries
- Sun Damage
- Freckles/Brown Spots
- Tone/Texture
- Back/Chest Acne
- Jowls (sagging skin)
- Uneven Skin
- Blackheads
- Lines/Wrinkles
- Unwanted Hair
- Burn
- Oiliness (Specify: _____________)
- Dark Under-Eye Circles
- Pre/Post-Operative Care
- Other: ________________
- Discoloration
- Razor Bumps
- Dry Skin
- Redness
- Elasticity Loss
- Rosacea
- Enlarged Pores
- Scarring
- Facial Hair
- Sunburns

Have you ever had any of the following treatments?

- Botox or Dysport
  When was your last treatment? ______________
- Restylane, Perlane, Juvederm, or other fillers
  When was your last treatment? ______________
- IPL (Intense Pulse Light)
  When was your last treatment? ______________
- Microdermabrasion
  When was your last treatment? ______________
- Peel (Lactic, Glycolic, Salicylic, Chemical)
  When was your last treatment? ______________
- Facial
  When was your last treatment? ______________
- Thermage
  When was your last treatment? ______________
- Laser Hair Removal
  When was your last treatment? ______________
- Cosmetic Surgery
  When was your last treatment? ______________
- Cosmetic Injections
  When was your last treatment? ______________
- Laser Treatments
  When was your last treatment? ______________

Do you Take/Use?

- Accutane- If, you have ever taken, ending when? ________________
- Cortisone Cream
- Hormone Replacement Therapy
- Oral Antibiotics
- Tretinoin, Retin A, Renova, Retinol, or any Retinoid

How long have you been using this medication? ____________________________
Sun Exposure History

Do you Sunburn/Tan Easily?  
__ Always Burn, Never Tan  
__ Seldom Burn, Tan Easily  
__ Never Burn, Tan Easily  
__ Usually Burn, Tan with Difficulty

Approximate Sun Exposure:  
__ Minimal  
__ Occasional  
__ Recreational  
__ Occupational

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma?  Yes ☐  No ☐

Have you been exposed to the sun or used a tanning bed in the last 48 hours?  Yes ☐  No ☐

How often do you use a Tanning Bed? ____________________________________________

Do you use an SPF Daily?  Yes ☐  No ☐

If Yes, which brand? _______________________

What level of SPF? _______________________

What is your Natural Coloring?
Eyes: ___________________ Hair: ___________________ Skin: ___________________

Have you ever had Skin Cancer?  Yes ☐  No ☐

If Yes, when and what kind: ________________________________________________

Do you use Prescription Medication for your skin?  Yes ☐  No ☐

If Yes, please list: ___________________________________________________________

What Skincare Products are you currently using?
____________________________________  _______________________________________
____________________________________  _______________________________________
____________________________________  _______________________________________
____________________________________  _______________________________________

Is there anything else that we should know? ________________________________

I HAVE STATED ALL MEDICAL CONDITIONS THAT I AM AWARE OF AND WILL UPDATE THE PRACTICE OF ANY CHANGES IN MY HEALTH STATUS.

SIGNATURE: ___________________________  DATE: _________________

PRINTED NAME: ________________________