

Please Print

**PATIENT HISTORY QUESTIONNAIRE**

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_ (May we call you at that phone#? yes, no)  
 (Or contact you via e-mail? yes, no)

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Ph: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Their phone: \_\_\_\_\_

Are you currently under a physicians care?  Specify: \_\_\_\_\_

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS

	Yes	No		Yes	No		Yes	No
Herpes Simplex	___	___	Epilepsy	___	___	Hyperpigmentation	___	___
Do you Smoke?	___	___	Keloid Scars	___	___	Liver Disease or Hepatitis	___	___
Eye Lid Injury	___	___	Chemotherapy/Radiation	___	___	Vitiligo	___	___
Do you wear Contacts?	___	___	Lupus	___	___	Cancer of any kind	___	___
Skin Cancer	___	___	Tuberculosis	___	___	Thyroid Disorder	___	___
Fainting/Dizzy Spells	___	___	Tumors/Growths	___	___	Phlebitis	___	___
Diabetes	___	___	Asthma	___	___	Bleeding Disorder	___	___
High Blood Pressure	___	___	Allergies	___	___			

ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING

Advil/Motrin       Aleve       Excedrin/Aspirin       Iron Pills       Blood Thinner       Accutane   
 Oral Antibiotics       Retin-A/Renova/Tazorae/Differin       Vitamin E       Prescription Acne Medications   
 Please list any other medications you are taking: \_\_\_\_\_

ALLERGIES

	Yes	No		Yes	No
Milk	___	___	Aspirin	___	___
Citrus Fruits	___	___			

Please list any other allergies to drug, make-up, skin care products or foods: \_\_\_\_\_

Have you been on Accutane in the past nine months? \_\_\_\_\_ Laser re-surfacing in the past year? \_\_\_\_\_

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

Are you pregnant? \_\_\_\_\_ Are you lactating? \_\_\_\_\_

Are you currently taking birth control pills? \_\_\_\_\_

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? \_\_\_\_\_ Coldsore? \_\_\_\_\_

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

What is your natural hair color? \_\_\_\_\_ Eye color? \_\_\_\_\_

When did you last tan your skin? \_\_\_\_\_ Sun, tanning bed, creams? \_\_\_\_\_

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

When a scar appears on your skin, is it significantly darker in color? \_\_\_\_\_

Are you currently taking any oral or injectable steroids? \_\_\_\_\_ If so, for what condition? \_\_\_\_\_

Please complete the next page

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

LIST ANY PREVIOUS COSMETIC TREATMENTS

---

---

---

LIST YOUR CURRENT SKIN CARE PRODUCTS AND REGIMEN

---

---

---

---

Going back 3 generations, what is your family ancestry? \_\_\_\_\_

---

What are you hoping to improve with your skin? \_\_\_\_\_

---

---

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_