

Patient History Questionnaire

Date: _____ Name: _____ Date of Birth: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ E-Mail: _____
 Employer: _____ Occupation: _____ Work Phone: _____
 Emergency Contact Person: _____
 Reason for Consultation: _____
 Are you currently under a physicians care? _____ Specify: _____
 How did you hear about Advanced Laser Medspa? _____ If Referral, who? _____

Have you ever had any of the following conditions? Check all that apply.

Allergies		Fainting/Concussion		Melanoma
Anemia		Hay Fever		Nervous/Emotional Disorders
Arthritis		Heart Disease		Phlebitis
Asthma/Wheezing		Heart Murmur		Radiation Therapy
Bleeding Disorder		Hepatitis A, B, or C		Sexually Transmitted Disease
Blepharoplasty		High Blood Pressure/ Hypertension		Sinus Problems
Blood Transfusion/ Donating		Hyper pigmentation		Skin Cancer
Chemotherapy/ Radiation		Herpes Simplex		Stomach Problems
Circulatory Problems		Infection (active)		Stroke
Cold Sores		Immune Disorders		Thyroid Problems
Diabetes		Kelioids		Tumors/Growths
Dizziness /Vertigo		Kidney Disorders		Tuberculosis Exposure
Eczema/Psoriasis		Liver Disorders		Ulcers

List all current medications/supplements that you take: _____

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

List any past or recent surgeries: _____

Do you have a latex allergy? _____yes _____No (I do NOT have a latex allergy)

Are you taking any oral or inject able steroids? _____ For what condition? _____

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Have you ever /are currently using any of the following? If so, how long?

Retin-A	YES	NO	Date: _____
Renova	YES	NO	Date: _____
Any Retinoic Acid Product	YES	NO	Date: _____
Accutane	YES	NO	Date: _____
Prescription Acne Medicine	YES	NO	Date: _____

For women only: Are you pregnant? _____ If so, how far along are you? _____

Are you currently taking birth control pills? _____

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

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

Have you recently undergone a skin peel? _____ 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? _____ How long ago? _____

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

Fitzpatrick Skin Test

Please circle the one that describes your skin type.

Type I: Always burn, never tans. Red or blond 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, etc.)

Type VI: African American

Skin Type: (circle one) Oily Normal Dry Sensitive Combination

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Please check any previous cosmetic treatments:

<input type="checkbox"/> Acid Peel/ Microdermabrasion	When? _____
<input type="checkbox"/> Laser Surgery	When? _____
<input type="checkbox"/> Collagen	When? _____
<input type="checkbox"/> Face Lift	When? _____
<input type="checkbox"/> Botox	When? _____
<input type="checkbox"/> Waxing	When? _____

Please check any allergies to the following:

<input type="checkbox"/> Soy	Reaction: _____
<input type="checkbox"/> Milk	Reaction: _____
<input type="checkbox"/> Eggs	Reaction: _____
<input type="checkbox"/> Sugar/Beets	Reaction: _____
<input type="checkbox"/> Retinoic Acid	Reaction: _____
<input type="checkbox"/> Aspirin	Reaction: _____
<input type="checkbox"/> Lidocaine	Reaction: _____
<input type="checkbox"/> Epinephrine/ Adrenaline	Reaction: _____
<input type="checkbox"/> Grapes	Reaction: _____
<input type="checkbox"/> Apples	Reaction: _____
<input type="checkbox"/> Tomatoes	Reaction: _____
<input type="checkbox"/> Citric Fruits	Reaction: _____

Please describe your skin: _____

What are you hoping to improve with your skin? _____

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

Patient Signature _____