HEALTH QUESTIONNAIRE

NAME:_____ **Date of Birth:**_____
Ethnic Origin:_____

Allergies (medications/foods/latex)	**Current Medications**	**In the past 2 weeks have you used:**
_____	_____	Retinols ? □Yes □No
_____	_____	Tetracycline? □Yes □No
_____	_____	St. Johns Wort? □Yes □No
_____	_____	Any other light
_____	_____	sensitive meds? □Yes □No

Skin Health *Check all that apply to your skin*

- □ Acne
- □ Rosacea/Redness
- □ Scarring
- □ Wrinkles
- □ Skin Laxity
- □ Fine Lines
- □ Excessive Dryness
- □ Excessive Oil
- □ Sun Damage/Age Spots
- □ Keloid Formation
- □ Cystic Acne
- □ Hyperpigmentation
- □ Hypopigmentation
- □ Eczema
- □ Psoriasis
- □ Rough Texture
- □ Dermatitis
- □ Tattoos
- □ Cold Sores
- □ Other _____

Previous Treatments

- □ Facial_____
- □ Laser_____
- □ Peel_____
- □ Botox/Dysport_____
- □ Fillers_____
- □ Silicone_____
- □ Spray Tan_____
- □ Surgery_____
- □ Other _____

Current Skin Care Products

- □ Cleanser_____
- □ Moisturizer_____
- □ Sunblock/SPF_____
- □ Toner/Astringent_____
- □ Mask/Scrub_____
- □ Eye Cream_____
- □ Night Cream_____
- □ Retinol/Glycolic_____
- □ Other _____

Have you ever been diagnosed with any skin conditions? _____

Past Medical History

Have you ever been diagnosed with any of the following conditions?

- □ Hypertension
- □ Diabetes
- □ High Cholesterol
- □ Heart Attack
- □ Stroke
- □ DVT/Pulmonary Embolus
- □ Heart Disease/Angina
- □ Asthma/Tuberculosis
- □ Migraines
- □ Intestinal Problems
- □ Thyroid Disease
- □ Seizure Disorder
- □ Kidney Disease
- □ Liver Disease/Hepatitis
- □ Breast Disease
- □ Arthritis
- □ Autoimmune Disease
- □ Cancer
- □ Blood Transfusion
- □ Porphyria
- □ Polycystic Ovary Disease
- □ Hormonal Disorder
- □ Bleeding/ Blood Disorder
- □ Skin Cancer/pre-cancerous lesions
- □ Herpes Simplex
- □ Systemic Lupus Erythematosis
- □ Scleroderma
- □ Immunosuppresive Disease
- □ Neuromuscular Disease
- □ Claustrophobia or Fear of Needles

Are you currently or could you be pregnant? _____ Do you wear contact lenses? _____
Are there any other health conditions we should be aware of? _____

SOCIAL HISTORY

Did you ever smoke? □Yes □No ___ #cigarettes/day How many years? ____ Year quit_____
Do you drink alcohol? □Yes □No ___ #drinks/week What Type of alcohol? _____
Have you ever used recreational drugs? □Yes □No What types?_____ Last use? _____
How many cups of caffeine do you consume in one day? _____ How many cups of water do you consume in one day? _____

Are you currently removing hair by any of the following methods? *Circle all that apply*
Depilatory (Nair type Products) Laser hair removal Waxing Tweezing Threading Electrolysis Other:_____

What aesthetic concerns apply to you? *Circle all that apply*

Acne	Enlarged pores	Dry patches	Clogged pores	Excessive oiliness
Uneven skin tone	Unwanted hair	Stretch marks	Cellulite	Wrinkles
Scarring	Varicose veins	Smile lines	Spider veins	Skin laxity
Brown spots (Hyperpigmentation)	White Spots (Hypopigmentation)	Unwanted Body Fat	Whiteheads/ Blackheads	Visible exposed Blood vessels

I certify the above information is accurate and complete to the best of my knowledge.

Patient Signature:_____ **Date:**_____