Patient Health Information Questionaire

Name: _____ Date:_____

Address:_____ City:_____ State:_____ Zip Code_____

Home Phone:_____ Cell Phone_____

Date of Birth:_____ E-Mail:_____

How did you hear about us? _____

Do you or have you ever had any of the following conditions?

__Aids
__Anemia
__ Arthritis
__Auto Immune Deficiency
__Asthma
__Blood Disorder
__Chemotherapy
__Diabetes
__Dizziness
__Epilepsy
__Fainting
__Hay Fever
__Heart Disease
__Hepatitis
__Infection
__Kidney Disease
__Liver Disease
__Lupus
__Melanoma
__Mental Disorder
__Nervous Disorder
__Radiation Treatments
__Respiratory Issues
__Skin Conditions
__Sinus Problems
__Stomach Problems
__Stroke
__Thyroid Disease

Allergies

__Milk __Aspirin __Seasonal
__Fruits __Sugar Cane
Medications_____
Cosmetics_____
Latex/Other_____

Have you ever/are you currently using:

Retin-A, Renova, retinoic acid	Yes/No
Accutane	Yes/No
Prescription Acne meds	Yes/No
Birth Control Pills	Yes/No
Steroids	Yes/No
Are you pregnant?	Yes/No
Are you lactating?	Yes/No

Previous Cosmetic Facial Treatments:

Acid Peels	Yes/No
Botox	Yes/No
Fillers	Yes/No
Tattoo/Perm.Makeup	Yes/No
Waxing	Yes/No
Facial Surgery	Yes/No
Laser Surgery	Yes/No
Microdermabrasion	Yes/No

Have you ever had?

Cold Sore	Yes/No
Fever Blister	Yes/No

If yes, how frequently?

List Current Medications: _____

List any questions you have: _____

SKIN EVALUATION

Type: ___ Normal ___Oily ___Dry ___Combination ___Other
Conditions: ___ Texture ___Sun Damage ___Acne/Oily ___Pigmentation Areas of Concern_____
___Sensitive ___Rosacea Other_____
Skin Sensitivity ___Always ___Usually ___Occasionally ___Rarely ___Never