# Skin Profile and Health History

Date: ________________________________

Last Name:____________________________ First:___________________ Middle:__________

Address: ______________________________________________________________________

City:______________________ State:_______ Zip:_________ Date of Birth:_______________

Home Phone: ________________ Work:_________________ Cell:______________________

E-mail: ________________________________ Occupation: ___________________________

How did you hear about us?________________________ Primary Care Physician:_____________

## ALL CLIENTS

Please specify your genetic origin – be as specific as possible (for ex: ½ Polish ¼ Irish ¼ Greek):

________________________________

________________________________

## FEMALES ONLY

(Circle one answer)

Are you pregnant? *Yes* *No* *Possibly*
Breastfeeding? *Yes* *No*

During pregnancy, did you develop masking or darkening of your skin? *Yes* *No* *n/a*
Are you going through menopause? *Yes* *No*

Please list all medications you are currently using (list both prescription and over the counter drugs):

_________________________________________________________________________________

___________________________________________________________________________

Are you allergic to any medications (please list them and describe reaction, if not state "none")?

______________________________________________________________________________

**Medical History:** (Please check all that apply, write in any conditions not listed)

□ Acne
□ Bleeding disorders
□ Botox injections
□ Burns/ skin grafts
□ Diabetes
□ Endocrine disorder
□ Epidermolysis bullosa
□ Hemorrhoids
□ Gold therapy
□ Heart disease
□ Filler injections (Restylane, Radiesse)

□ High blood pressure
□ Hirsutism
□ Hormone replacement
□ Implants
□ Kaposi's sarcoma
□ Keloid scars
□ Lupus
□ Permanent makeup
□ Polycystic Ovary disease
□ Port-wine stain

□ Rosacea
□ Seizures
□ Shingles
□ Skin Cancer
□ Tattoos
□ Thyroid disease
□ Vitiligo
□ Pacemaker
□ Vascular disease
□ Precocious puberty
□ Other conditions not listed:

□ Melasma
□ Scleroderma
□ Psoriasis
□ Herpes

___________________________________________________________________________

| # | Question | Y | N |
|---|---|---|---|
| 1. | Have you had skin cancer or pre cancerous lesions? | Y | N |
| 2. | Has any member of your family had skin cancer? | Y | N |
| 3. | Do you have psoriasis/eczema in the area to be treated? | Y | N |
| 4. | Are there any moles with hair in the area to be treated? | Y | N |
| 5. | Are you allergic to latex, lidocaine, or any lotions? | Y | N |
| 6. | Have you ever had surgery in the area to be treated? | Y | N |
| 7. | Have you had any previous laser treatments or other skin treatments to the the area to be treated? Describe: ___________________________________ | Y | N |
| 8. | Have you /are you using medications such as Accutane? Dates: ________ | Y | N |
| 9. | Are you using Retin-A, Renova, Differin, Tazorac? Concentration_____% | Y | N |
| 10. | Are you using glycolic/AHA home care products? | Y | N |
| 11. | What skin care products are you currently using?____________________ ______________________________________________________________ | | |
| 12. | Do you smoke? | Y | N |
| 13. | Do you sunbathe? If yes, approximate date of last sun exposure________________________ | Y | N |
| 14. | Are you currently using, or have you used a tanning bed or self tanner? If yes, specify with date of last use________________________________ | Y | N |
| 15. | Do you use a sunscreen? Summer-SPF_____ Winter-SPF_____ | Y | N |
| 16. | Do you use facial depilatories? _____________Hot wax?__________ | Y | N |
| 17. | Does your skin remain discolored after healing from a cut? | Y | N |

**Please indicate which of the following concerns you have about your skin?**

| | | | |
|---|---|---|---|
| □ Aged Skin | □ Sun Damage | □ Rosacea | □ Age Spots |
| □ Acne | □ Englarged Pores | □ Blackheads | □ Texture |
| □ Redness | □ Wrinkles | □ Whiteheads | □ Other: |
| □ Leg Veins | □ Hair Removal | □ Oily Skin | ________ |
| □ Spider Veins | □ Unevenness | □ Dry Skin | ________ |
| □ Scarring | □ Hyperpigmentation | □ Sensitive Skin | ________ |

**What are would you like to treat:**

□ Face & Neck □ Chest □ Arms □ Hands □ Back □ Legs □ Other: __________________________

**Please specify areas which you would like to consider for laser hair removal:**

_____________________________________________________________________________________

_____________________________________________________________________________________

**Please indicate the service you are interested in or would like more information on:**

| | | |
|---|---|---|
| □ Laser Skin Rejuvenation | □ Rosacea Treatment | □ Acne Treatment |
| □ Laser Vein Treatment | □ Sun Damage Repair | □ Age Spot Treatment |
| □ Laser Hair Removal | □ Botox/Dysport | □ Other: |
| □ Pigment Treatment | □ Filler Injections | _________________ |
| □ Wrinkle Treatment | □ Redness/Vessels | _________________ |

**I confirm that the answers to the questionnaire are true and correct:**

Signature of Client:_________________________________________________ Date:_______________

Signature of Consultant:______________________________________________Date:_______________

Reviewed by Nurse:__________________________________________________ Date:_______________

Reviewed by Medical Director:_________________________________________Date:_______________