General Information / Health History Profile

General Information

Last Name: _____ First Name:_____Middle Initial:_____

Mailing Address:_____City:_____ State:_____ Zip:_____

Date of Birth: _____ Age:_____

Home Phone:(____)_____ Work Phone(____)_____ Cell Phone:(____)_____

Occupation:_____ Ethnicity:_____

Sex: M / F Height:_____ Weight:_____

Health History

Have you ever seen a doctor for any skin condition? If so, when and who did you see? _____

_____

Have you ever had, used or taken:

- ❑ Accutane When:_____ Dosage:_____ Duration:_____
- ❑ Steroid Medications When:_____ Dosage:_____ Duration:_____
- ❑ Radiation to head/neck When:_____ Dosage:_____ Duration:_____
- ❑ Retin-A When:_____ Dosage:_____ Duration:_____

- ❑ Lupus
- ❑ Skin Cancer
- ❑ Herpes Simplex (fever blisters)
- ❑ Diabetes
- ❑ Rheumatoid Arthritis
- ❑ Fibromyalgia
- ❑ Photosensitivity
- ❑ HIV
- ❑ Wound Healing Problems
- ❑ Vitiligo
- ❑ Hepatitis
- ❑ Keloid Scarring

Any conditions or illnesses not listed?_____

Allergies:_____

Do you smoke? Yes / No Do you drink? Yes / No

Are you pregnant or planning to be? Yes / No

Skin Analysis

How do you describe your skin?

Oily Dry Sensitive Combination (oily t-zone)

Do you have?

- ❑ Acne
- ❑ Whiteheads
- ❑ Broken Capillaries
- ❑ Cysts
- ❑ Blackheads
- ❑ Pigmentation Problems
- ❑ Pustules
- ❑ Scarring
- ❑ Pimples
- ❑ Wrinkles
- ❑ Open Wounds
- ❑ Large Pores

What skin care products are you currently using?_____

_____

_____

What would you like to change about your skin?_____

_____

Do you wear contacts? Yes / No

Are you looking for a new skin care regimen? Yes / No

Would you like more information about surgical skin care options? Yes / No

How did you hear about us?_____