HEALTH INFORMATION FORM

Patient Name:_____________________________ Date of Birth:__________________ Today's Date:_______________

Address:____ City, State, Zip:____________________________________

Home Phone: ( )__________________ ☐ Work: ( )____________________ ☐ Cell: ( )_________________ ☐
(Place an X In the Appropriate Box Above To Indicate Your Preferred Contact Method)

E-mail:______________________________Occupation:______________________Employer:________________________
(Used for Office Correspondence Only)

Primary Care Physician:____________________ Phone: ( )______________

Are You Currently Under a Physicians Care? Y / N Please Specify:_____________________________________

How did you hear about us?_____________________________Referrer's Name (if applicable)______________________

Emergency Contact:______________________________ Relationship To Patient: ________________________________

Contact's Phone: ( ) _________________________ Reason for Consultation?__________________________________

Have you ever had any of the following conditions?
(check all that apply)

____AIDS/HIV
____Anemia
____Arthritis
____Auto Immune Defiency
____Asthma
____Blood Disease
____Chemotherapy (active)
____Contacts
____Diabetes
____Dizziness
____Epilepsy
____Eye Surgery
____Fainting
____Hay Fever
____Heart Murmur
____Heart Disease
____Hepatitis
____Herpes
____High Blood Pressure
____Keloid Scarring
____Kidney Disease
____Liver Disease
____Lupus
____Melanoma
____Mental Disorder
____Nervous Disorder
____Phlebitis
____Radiation Treatment
____Respiratory Problems
____Skin Conditions
____Sinus Problems
____Smoke
____Stroke
____Thyroid Problems
____Tuberculosis
____Ulcers
____Venereal Disease

ALLERGIES – Please List | Have you ever had: (Circle)

Medication **Allergies**:___________________________
Cosmetic **Allergies**:_____________________________
Latex/Other **Allergies**:__________________________

Cold Sore:	YES		NO
Fever Blister:	YES		NO
Frequency:	<1/year	1-3/year	4+/year

Have you ever/are you currently using: (Circle)

Retin-A, Renova or any retinoic product:	YES-Currently	YES-In the Past	NO
Accutane:	YES-Currently	YES-In the Past	NO
Prescription Acne Medication:	YES-Currently	YES-In the Past	NO
Birth Control Pills/Patch:	YES-Currently	YES-In the Past	NO
Steroids:	YES-Currently	YES-In the Past	NO

WOMEN: Are you pregnant?__________ If yes – Due Date?________________ Are you lactating?___________

Please list all **current medications/supplements** that you take (including topical medications):______________________________
____
____
____

HEALTH INFORMATION FORM – cont.

Previous Cosmetic Treatments (Circle)				What are your concerns about your skin?	
Acid Peel:	YES	NO	Date:__________	*Fine Lines	*Blackheads
Microdermabrasion:	YES	NO	Date:__________	*Deep Lines	*Large Pores
Botox:	YES	NO	Date:__________	*Skin Texture	*Hyperpigmentation
Collagen/Restylane:	YES	NO	Date:__________	*Sun Damage	*Hypopigmentation
Tattoo:	YES	NO	Date:__________	*Acne	*Rosacea
Permanent Makeup:	YES	NO	Date:__________	*Acne Scars	*Scarring
Waxing:	YES	NO	Date:__________	*Cellulite	*Visible Veins
Facial Surgery:	YES	NO	Date:__________		
Laser Surgery:	YES	NO	Date:__________		
Sclerotherapy:	YES	NO	Date:__________		

What is your natural hair color?__________________________ Eye Color?________________________________

Is your skin condition normal or abnormal?____

When did you last tan your skin?_____________________ Sun, tanning beds, creams?______________________

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

In your own words, describe your skin.____

What are you hoping to improve with your skin?____

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

Please list your skin care regimen:

AM Cleanser:____

Treatment:____

Moisturizer:____

SPF:____

Make-up:____

Other:____

PM Cleanser:____

Treatment:____

Moisturizer:____

Other:____

***In an effort to keep our patients informed, we periodically send monthly email correspondence. By signing below, I acknowledge and consent to receiving these emails. I may, however, opt-out at any time provided written notice is given.**

***In order to control our costs of billing, we request that office visits be paid at the time service is rendered. Acceptable forms of payment are Cash, Visa, American Express and MasterCard. We apologize, but we do not accept Checks or Discover.**

Patient Signature:____ Date:____________