

### SKINCARE PATIENT HEALTH HISTORY

Complete the information on this form and bring a printed copy to your appointment.

Date \_\_\_\_\_ Referred by \_\_\_\_\_

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (home) \_\_\_\_\_ Phone (cell) \_\_\_\_\_ E-mail \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Do you have any allergies or sensitivities? Yes No If yes, please list \_\_\_\_\_

Are you currently taking any medications? Yes No If yes, please list name, frequency and dosage \_\_\_\_\_

Are you currently taking any aspirin, ibuprofen, minerals, herbs or nutritional supplements? Yes No

If yes, please list. \_\_\_\_\_

Are you pregnant, nursing, or planning a pregnancy? Yes No

Have you experienced any of the following?

High or Low Blood Pressure	Yes	No	Diabetes	Yes	No
Seizures or convulsions	Yes	No	Fainting or dizzy spells	Yes	No
Stroke	Yes	No	Blood transfusion	Yes	No
Asthma	Yes	No	Thrombophlebitis	Yes	No
Pulmonary embolus	Yes	No	Deep vein thrombosis	Yes	No
Septicemia	Yes	No	Autoimmune disease (lupus, MS)	Yes	No
Hepatitis	Yes	No	Hemophilia/bleeding disease	Yes	No
Easily bruise	Yes	No	Heart disease	Yes	No
Migraine headaches	Yes	No	HIV/aids	Yes	No
Dark spots after pregnancy or injury	Yes	No	Rheumatoid arthritis	Yes	No
Cancer	Yes	No	Skin cancer	Yes	No
Scleroderma	Yes	No	Cold sores/herpes simplex	Yes	No
Keloid scars	Yes	No	Abnormal response to light	Yes	No
Treatment with Coumadin or Heparin	Yes	No	Treatment with Accutane	Yes	No
Hormone Replacement Therapy	Yes	No	Abnormal heart condition	Yes	No
Circulatory problems	Yes	No	Epilepsy	Yes	No
Tumors or cysts	Yes	No	Chemotherapy or radiation	Yes	No
Cataracts / dry eye	Yes	No	Corneal abrasions	Yes	No
Eye or eyelid surgery	Yes	No	Contacts	Yes	No
Visual disturbances	Yes	No	Other _____		
Depression / Severe mood swings	Yes	No			

What are your areas of concern? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed By \_\_\_\_\_ Date \_\_\_\_\_