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COSMETIC AND SKINCARE HISTORY

It is very important that the information given is complete and accurate in order for me to provide you the best healing experience possible. Please PRINT clearly. If you have questions, please ask. All information provided is confidential.

Today's Date: _____/_____/_____

GENERAL INFORMATION

Legal Name _____ Preferred Name/Nickname _____

Date of Birth _____ Gender Identity/Pronoun(s) _____

Address _____ City _____ State _____ Zip Code _____

Preferred Phone Number (_____)_____ Ok to leave a medical related voicemail at this number? ____Y ____ N

Email address _____ Ok to send medical related messages to this email? ____Y ____ N

Minors Under 18 - Parent/Responsible Party Information

Name _____ Relationship to Patient _____

Date of Birth _____ Phone Number (_____)_____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____

Phone Number (_____)_____

HEALTH AND MEDICAL INFORMATION AND HISTORY

Do you have a primary care doctor that you see annually? _____Y _____N

Are you currently under the care of a dermatologist?____Y ____ N If yes, what for? _____

Do you have any of the following medical conditions? (Please check all that apply)

____ Cancer ____ Diabetes ____ High blood pressure ____ Herpes ____ Arthritis ____ Frequent cold sores ____ HIV/AID

____ Keloid scarring ____ Skin disease/Skin lesions ____ Seizure disorder ____ Hepatitis ____ Hormone imbalance

____ Thyroid imbalance ____ Blood clotting abnormalities ____ Any active infection

Please list any other health problems or medical conditions not listed above:_____

Describe your general health _____

List all medications, herbs or supplements you are currently taking (blood thinners, painkillers, antibiotics, antidepressants, herbs, multivitamin, etc.) _____

_____

List any major illnesses, hospitalizations or surgeries: _____

_____

List any allergies to liniments, lotions, ointments, oils, essential oils, nuts, etc. _____

_____

Are you pregnant? ____Y ____ N If yes, how many weeks? _____ Are you trying to pregnant? ____Y ____ N

Are you breastfeeding? ____Y ____ N Do you use contraception? ____Y ____ N

Do you smoke or vape? ____Y ____ N ____ Former If yes, what, and how much/how often per day?_____

Please answer the following questions:

Are you in the sun often? ____Y ____N Do you wear protective gear or sunscreen? ____Y ____N

Do you regularly use tanning salons or sun bathe? ____Y ____N If yes, how often? _____

Do you, or any immediate family members, have or have had skin cancer? ____Y ____N If yes, please explain:

_____

_____

Do you have a history of bad sunburns? ____Y ____N If yes, please explain: _____

Do you use facial masks? ____Y ____N If yes, how often? _____

Do you exfoliate? ____Y ____N If yes, how often? _____

Do you wear makeup? ____Y ____N If yes, what type of makeup do you wear? _____

Have you had cosmetic surgery? ____Y ____N If yes, please list procedure(s) and how long ago:

_____

Do you get any of the following in-office cosmetic procedures?

- ☐ Botox
- ☐ Dermal Fillers
- ☐ Microdermabrasion
- ☐ Chemical Peels
- ☐ Facial Waxing/Depilatories
- ☐ Juvéderm
- ☐ Restylane
- ☐ Cosmetic Tattoo
- ☐ Laser Hair Removal
- ☐ Laser Skin Resurfacing
- ☐ Other: _____
- ☐ Other: _____

Do you use any of the following skincare medications/topicals?

- ☐ Retin-A
- ☐ Retinol
- ☐ Salicylic Acid
- ☐ Glycolic Acid
- ☐ Azelaic Acid
- ☐ Differin
- ☐ Renova
- ☐ Avage
- ☐ Hydroquinone
- ☐ Accutane
- ☐ Adapalene
- ☐ Other Vitamin A topicals: _____

If yes to Accutane, are you currently receiving or have received in the last 6 months? _____ Y _____ N

Which of the following best describes your skin type (mark all that apply):

- ☐ Normal
- ☐ Dry
- ☐ Oily
- ☐ Combination
- ☐ Sensitive
- ☐ Mature/Aging
- ☐ Acne Prone
- ☐ Sun Damaged

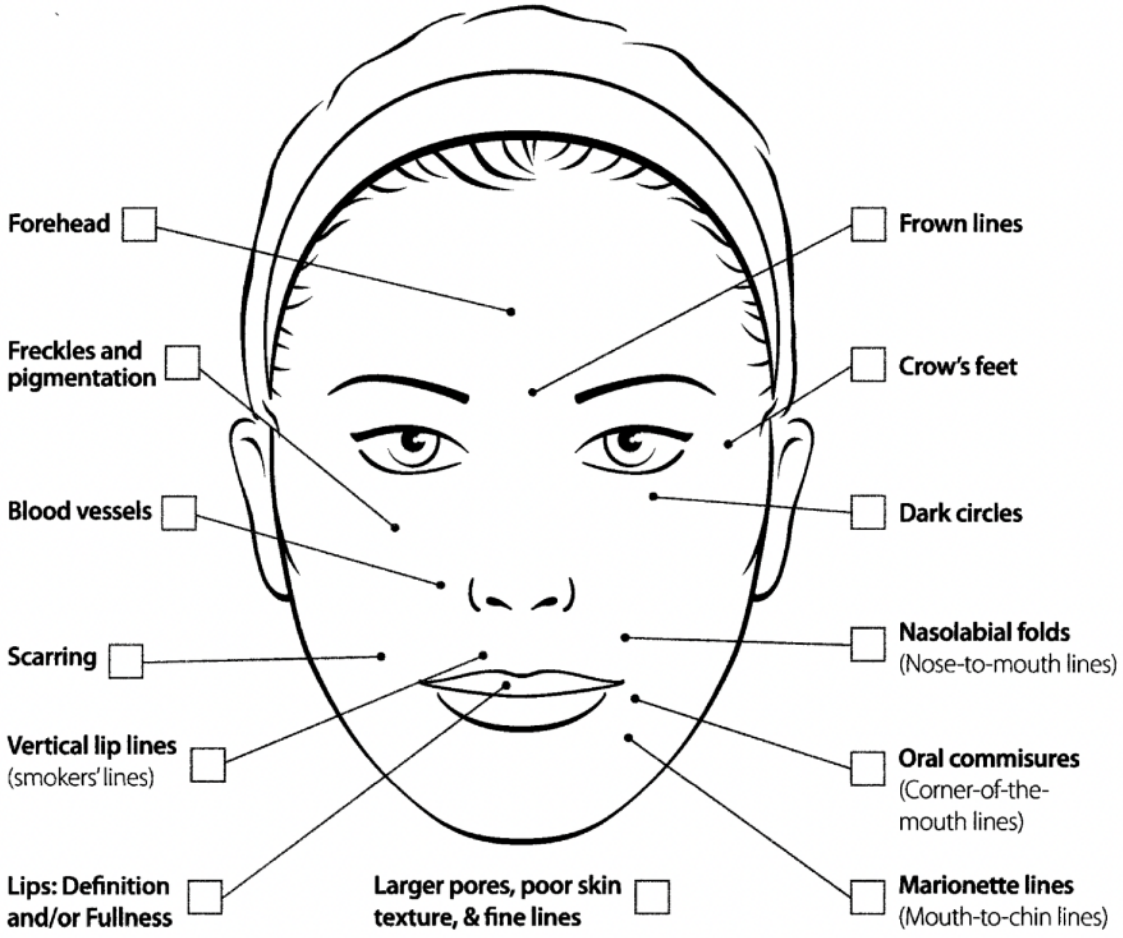
Areas of concern (Mark all that apply):

- ☐ Acne/Blackheads
- ☐ Acne scars
- ☐ Other scars (accident/surgical)
- ☐ Rosacea
- ☐ Sallow Complexion
- ☐ Dull/Lusterless Complexion
- ☐ Dryness
- ☐ Fine lines
- ☐ Wrinkles
- ☐ Enlarged Pores
- ☐ Discoloration
- ☐ Loss of skin tone
- ☐ Swelling/Puffiness
- ☐ Dark Circles Under Eyes/Eye Bags
- ☐ Hyperpigmentation/Brown Spots/ Pregnancy Mask/Melasma
- ☐ Broken capillaries/veins
- ☐ Aging prevention

What are your treatment goals: _____

_____

Please write any information you think I may need to know in order to best serve you: _____

_____

On the diagram below, please check off areas of concern. You may add your own as needed.