

MEDICAL HISTORY FORM

Name _____ Home Phone _____
Address _____ Cell Phone _____
City _____ State _____ Date of Birth _____
Zip Code _____ DL# _____ Sex ___ M ___ F Age ___ SS# _____
Email Address _____
Patient's Employer _____ Occupation _____
Employer's Address _____ Work Phone _____
City _____ State _____ Zip Code _____
Any other family members who have been treated here? ___ Yes ___ No Name _____
How did you find out about our practice? _____

RESPONSIBLE PARTY

Name of Responsible Party _____ Date of Birth _____
Address _____ Home Phone _____
Relationship: Husband/Wife/Father/Mother/Son/Daughter _____ Occupation _____
Employer _____ Work Phone _____
Employer's Address _____
City _____ State _____ Zip Code _____

IN CASE OF EMERGENCY CONTACT

Name _____ Relationship _____
Address _____ Telephone _____

Our Notice of Privacy Practices (notice) provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As outlined in our notice, the terms of our notice may change. If our notice is changed or modified, you may obtain a revised copy by request from the receptionist.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as though original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.

Signature

Date

Patient Profile

Last Name _____ First _____ Middle _____

Date of first visit _____ Skin Health Counselor _____ Physician _____

PATIENT PROFILE HISTOLOGY

Allergies _____ Medications _____
Have you ever taken Accutane? _____ When? _____ Dosage _____ Months _____
Have you used Tretinoin? ___% ___ Do you have herpes simplex? ___ Valacyclovir ___ Zovirax ___ Valtrex ___
Birth Control Pills? _____ Currently pregnant? _____ Breast feeding? _____ Attempting Pregnancy? _____
Skin tans? ___ Skin burns? ___ Pre-cancerous lesion? ___ Lesion removal? ___ When _____
Mole removal? _____ When? _____ Hair removal? ___ Wax ___ Electrolysis ___ Laser ___
Permanent make-up? ___ Where? _____ Filler? ___ What kind? _____ Where? _____
Other _____

PREVIOUS RESURFACING PROCEDURES (please give dates)

CO2 _____ Erbium _____ Dermabrasion _____ Microdermabrasion _____
Peels: Phenol _____ TCA _____ Obagi Blue Peel _____ Glycolic _____
Salicylic _____ Vitalize Peel _____
Other treatments _____

HOME SKIN CARE PRODUCTS

Cleanser _____ Times a day _____ Toner/Astringent _____
Moisturizer _____ Eye Cream _____ Exfoliator _____
Sunscreen _____ Other _____ Make-up _____
Topical Medications _____

AREAS OF CONCERN (please check all that apply)

Lines/wrinkles _____ Skin texture _____ Skin elasticity _____ Even color tone _____ Psoriasis/Eczema _____
Acne Scars _____ Acne (pimples, whiteheads, blackheads) _____ Skin disorder _____
Other concerns _____

SELF SKIN ANALYSIS (please check all that apply)

Oily ___ X-Dry ___ Dry ___ Normal ___ Combination ___ Thick ___ Thin ___ Normal ___ Other ___
Wrinkles? ___ Fine ___ Deep ___ Acne? ___ Type _____ Acne Scars? ___
Other Scarring _____
Keloids ___ Scarring ___ Pigmentation ___ Telangiectasias ___ Milia ___ Comedones ___
Enlarged Pores ___ Elastosis ___ Keratosis ___

SKIN COLOR ANALYSIS

Caucasian ___	Light ___	Medium ___	Dark ___	Very Dark ___
Asian ___	Light ___	Medium ___	Dark ___	Very Dark ___
Hispanic ___	Light ___	Medium ___	Dark ___	Very Dark ___
African American ___	Light ___	Medium ___	Dark ___	Very Dark ___
Indian ___	Light ___	Medium ___	Dark ___	Very Dark ___
Ethnic Combination ___	Light ___	Medium ___	Dark ___	Very Dark ___

Please complete the following questionnaire as this will help us properly address the issues important to your health:

Please list the purpose of your visit:

Present Health Concerns:

Medical History

Are you presently receiving medical treatment for any condition(s)? Yes No

If yes please list condition(s)

Condition	How Long

Medications

Please list any medications you take regularly. Prescription, non-prescription, vitamins, home remedies, birth control pills, and herbs: None

Medication (including strength)	How many times a day	How long taken

Allergies

Are you allergic to any medications? (If yes, please list below) Yes No
