PRIMARY AESTHETIC

Skin Care

Patient Profile - Medical History

Name:_____Sex:_____Age:_____Date of Birth:_____

Address:_____City:_____State:_____Zip_____

Home phone:_____Cell /Alt. Phone:_____Today's Date:_____

Occupation:_____E-mail address:_____Weight_____

Preferred Method of Contact (Please "X"): _____E-mail _____Home Phone _____Alt. Phone

Emergency Contact (Name & Phone):_____

How did you hear about Primary Aesthetic Skin Care:_____

1. Have you ever had or been treated for: ("X" all the apply)

- ☐ Cold sores
- ☐ Skin rash /disease
- ☐ Heart trouble
- ☐ Cancer
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Bleeding problems
- ☐ Allergy /fever
- ☐ Asthma or wheezing
- ☐ Shortness of breath
- ☐ Tuberculosis
- ☐ AIDS /ARC
- ☐ Nervousness /anxiety
- ☐ Back problem /pain
- ☐ Dizziness /fainting spells
- ☐ Head injury
- ☐ Neuritis (nerve inflammation)
- ☐ Mitral valve prolapse
- ☐ Drug or alcohol addiction
- ☐ Frequent severe headaches
- ☐ Phlebitis of veins
- ☐ Epilepsy
- ☐ Eye injury or disease
- ☐ Swollen /painful joints
- ☐ Rheumatism /arthritis
- ☐ Tendonitis
- ☐ Ankle /feet swelling
- ☐ Varicose veins

2. List other diseases or illnesses you have had:

_____

_____

_____

Patient Name: _____

3. **List all prescription and non-prescription medication you are currently taking or have recently taken (in past two weeks): ("X" all that apply)**

- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Blood pressure
- ☐ Insulin /other diabetic medications
- ☐ Thyroid
- ☐ Cold /Allergy medications
- ☐ Testosterone /estrogen
- ☐ Tranquilizers /Anti-depressants
- ☐ List others: _____
- ☐ Antibiotics
- ☐ Herbal supplements /Vitamins
- ☐ Tazorac
- ☐ Retin-A /Renova /Differin /Hydroquinone
- ☐ Accutane –when stopped **(must stop 3-6 months prior to peeling)**:

4. List below all hospitalizations for illnesses, operations, accidents or fractures:

Year:_____ Reason:_____

Year:_____ Reason:_____

Year:_____ Reason:_____

Year:_____ Reason:_____

5. Do you drink alcohol?

- ☐ No
- ☐ 1-2 drinks /week
- ☐ 3-5 drinks /week
- ☐ 5+ drinks /week

Do you smoke?

- ☐ Never smoked
- ☐ Less than 1 pack /day
- ☐ More than 1 pack /day
- ☐ Former smoker

6. **Primary physician: (Name, telephone, date of last physical)**

_____

_____

7. **When you go to the dentist:**

Do you require antibiotics be used? YES / NO

Do you require extra numbing medication? YES / NO

8. **Pharmacy name and telephone: _____**

9. **WOMEN ONLY:**

Are you pregnant? Y/ N Due Date: _____

Date of your last menstrual period: _____

Are you currently lactating? Y/ N

***If pregnant or breastfeeding, a chemical peel is contraindicated.**

Patient Name: _____

10. Allergies:

Are you allergic /sensitive to ("X" all that apply):

☐ Lidocaine	☐ Perfumes	☐ Mushrooms	☐ Aloe Vera
☐ Adhesives	☐ Milk	☐ Apples	☐ Alcohol-based
☐ Latex	☐ Eggs	☐ Grapes	products:_____
☐ Aspirin	☐ Hydroquinone	☐ Citrus	☐ Other:_____

List other allergies to any medication:_____

Have you ever used any products that caused a bad reaction? YES / NO

If yes, describe: _____

Have you ever had a skin allergy or sensitivity? (Rash, irritation, peeling, swelling, hives, etc.)? YES / NO

11. Skin Description: (Describe your skin, "X" all that apply)

☐ Thick	☐ Dry	☐ Eczema	☐ Acne
☐ Thin	☐ Oily	☐ Psoriasis	☐ Dehydrated (lack of moisture)
☐ Loose	☐ Mature	☐ Sun-damaged	
☐ Firm	☐ Wrinkled	☐ Hyper-pigmented (excess pigment)	☐ Patchy dryness on_____
☐ Freckled	☐ Melasma (mask of pregnancy)	☐ Hypopigmented (lack of pigment)	
☐ Uneven /blotchy			
☐ Normal	☐ Rosacea		

Do you consider yourself:

☐ Sensitive to touch or pain	☐ Tolerant	☐ Not sure
	☐ Resilient	

Skin tone:

☐ Pale /white	☐ Lt. Olive	☐ Dark Brown
☐ Light	☐ Med. Olive	☐ Soft Black
☐ Medium	☐ Dark Olive	☐ Black
☐ Reddish	☐ Lt. Brown	
☐ Freckled	☐ Med. Brown	

Describe your ethnic background (English, Hispanic, Italian, German, Asian, Native American, African American, etc.) _____

Do you redden or flush easily when you eat spicy food, drink alcohol, get angry, go in the sun, etc.? YES / NO

Patient Name: _____

12. Improvements you are seeking:
Current appearance problems /goals that brought you to the Primary Aesthetic Skin Care:

_____

Appearance wish list (anything about your appearance that you wish you could change or improve):

_____

What non-surgical cosmetic medical procedures would you like to learn more about? ("X" all that apply)

- ☐ Botox /Dysport
- ☐ Dermal Fillers (Restylane, Juvederm, Radiesse, etc.)
- ☐ Laser
- ☐ MicroPen /PRP
- ☐ Hair Reduction
- ☐ Laser Skin Rejuvenation (Photofacial, Pigmented Lesions, etc.)
- ☐ Acne
- ☐ Rosacea
- ☐ Melasma
- ☐ Psoriasis
- ☐ Scar Revision
- ☐ Vascular Lesions, etc.

13. Do you have permanent makeup? YES / NO **Do you wear contacts?** YES / NO

14. Have you recently undergone any surgery or laser treatments in the area to be treated? YES / NO

If yes, please provide detail: _____

15. Do you receive injectables? (Botox, fillers) YES / NO **Do you develop cold sores?** YES / NO

16. Have you recently had facial or body waxing or used at-home depilatories? YES / NO

17. Do you currently have sunburn or wind-burned skin? YES / NO ***If yes, we may not treat you**

18. Do you have extended outdoor plans in the next 7 days? YES / NO

19. Do you plan to participate in vigorous exercise in the next 72 hours? YES / NO

20. Have you had any active skin care treatments in the past 21 days? YES / NO

If yes, how long ago? _____

21. List all topical products applied in the last 7 days _____

_____

Patient /Patient Representative Signature Print Name

_____

Date

This is a confidential report of your medical history and will be kept in this office. Information contained herein will not be released to any person or organizations except when you have authorized us to do so.