

PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Cell # or Preferred Contact #: _____ Is it important to be discrete? _____

Place of Employment: _____

Email: _____ Social Security #: _____

Emergency Contact: _____ Phone #: _____

How did you hear about us? _____

What services are you interested in? _____

Medical History:

Heart Condition: **yes no**

Keloids: **yes no**

Dry Eyes: **yes no**

Diabetes: **yes no**

Cold Sores/Herpes: **yes no**

Glaucoma: **yes no**

Perm Makeup/Tattoos: **yes no**

Pregnant or Lactating: **yes no**

Thyroid Disease: **yes no**

Have you been on Accutane in the past 6 months? : **yes no**

List all medications you are currently taking (blood thinners, antibiotics, herbs, supplements, vitamins, aspirin etc.): _____

Have you had any cosmetic or eye surgery in the past? Please list: _____

Allergies: _____

Acne:

Do you have a history of breakouts? **yes no**

If so, what is the frequency of your breakouts? **Frequent Occasional Rarely**

Do you experience cystic breakouts? **yes no**

Do you have any scarring as a result from your acne? **yes no**

Skin Background:

Have you had prolonged sun exposure (or tanning bed) in the past 3 days? **yes no**

Do you use tanning beds? : **yes no**

Are you using chemical tanning solutions? **yes no**

Do you use sunscreen on a regular base? **yes no** What SPF? _____

