Medical History

Name: ____

Address: ____

City: _________________________________State: ___________Zip:__________________

Date of Birth: ___________________________________ Circle one: Male or Female

Home Phone: ______________________Cell Phone: ________________________________

Occupation: _______________________ Employer: ________________________________

Pharmacy name/location/number: ____

____

How did you hear about us? ____

Reason for today's visit: ____

Do you have any particular skin problem or concerns? ____________________________

Do you have any known allergies? ____

Please list your parent's ethnic background: ____________________________________

What is your e-mail address? ____

To the best of my knowledge, the information I provided is true. I understand that this information is confidential and will not be disclosed without my written consent.

Patient or Legal Guardian Signature: ___________________________Date: ______________

Allen Aesthetics and Laser Center Medi-Spa

Skin Assessment- Chemical Peels

Patient's Name:___________________________Age:______Date___________

Are you currently under the care of a physician for your skin? Y N
If yes, why?____
Have you ever seen a dermatologist, or other physician for your skin? Y N
If yes, when and why?____
Have you previously had:
Chemical Peel? Y N Type of Peel_______________Date_____________
Laser Resurfacing, Dermabrasion, Phototherapy or Microdermabrasion? Y N
Type/Depth________Date__________
Facial Surgery? Y N Procedure________________Date_____________
Have you done any aggressive exfoliation to your skin in the last 2 weeks? Y N
If yes, explain:____
What skincare products do you use frequently?_____________________________
Are you taking Accutane? Y N
If yes, what is the dosage and frequency?__________________________________
Have you ever taken Accutane? Y N If yes, last taken on?________________
What topical medications do you use or have you used? Retin-A Hydroquinone
Have you ever used a topical fluorouracil preparation on your skin? Y N
If yes, when?______________________On what area of your body?____________
Other: (this includes topical antibiotics, OTC acne remedies, Hydroquinone, etc.)____
Please list any oral medications you currently take:
(This includes hormones, birth control pills, antibiotics, tranquilizers, anti-depressants, diuretics, etc.)
Please list any nutritional supplements you take:_____________________________
HYPERSENSITIVITY AND SKIN FRAGILITY:
Have you ever had a skin allergy or sensitivity? (rash, irritation, peeling, swelling, hives, etc.) Y N
to: cosmetics fabrics other: (i.e. latex, etc.)___________________
Do you have any known allergies to anything? Y N
If yes, please list all allergies: (this includes medications, aspirin, food, etc.)____
Do you "flush" or "appear reddened" easily when you eat spicy food, drink alcohol, get angry, go in the sun, etc.? Y N
FREE RADICAL EXPOSURE:
Do you smoke? Y N How much?_____________________________
Do you consume alcohol? Y N How much?_____________________________
Do you have a healthy diet? Y N List any dietary concerns:__________________
Do you exercise? Y N How much?__________Type_______________
Do you take vitamins? Y N Multi-Vitamins:__________Antioxidants________
Do you drink water? Y N How many glasses per day?_________________
FOR WOMEN ONLY:
Do you have regular periods? Y N
Are you going through menopause? Y N
Are you pregnant or lactating? Y N
Have you ever been pregnant? Y N
Are you trying to become pregnant? Y N
If yes, during pregnancy did you ever experience hyperpigmentation or a "pregnancy mask"? Y N

PIGMENTATION (Fitzpatrick Scale):
How much do you tan?
I Burn **II** Usually Burn **III** Sometimes Burn
IV Rarely Burn **V** Never Burn-"Brown" **VI** Never Burn-"Black"
Pigmentation: Even Uneven Birthmark Pregnancy Mask
What is your Ethnicity and Race (heritage)?_________________________________

VASCULARITY: (telangiectasia or broken capillaries):
Nose area Cheek area Chin area Forehead Entire Face

ACNE:
Do you have any history of acne or periodic breakouts?
Pimples White Heads Blackheads Enlarged Pores
Acne Scars Cysts Flakiness
Do you only experience breakouts during or around your menstrual cycle? Y N
Do you always have a pimple or some type of breakout? Y N

FACIAL WRINKLES: Deep Wrinkles Crows Feet Fine Lines
Have you been treated with Botox Collagen
If yes, date of last treatment: ___________________

SKIN TYPE:
Does your skin ever flake or feel tight and dry? Frequently Occasionally Very Rarely
Is your skin ever shiny a few hours after cleaning? Frequently Occasionally Very Rarely
How often do you experience blackheads or blemishes? Frequently Occasionally Very Rarely
How noticeable are your pores? Frequently Occasionally Very Rarely

ABILITY TO HEAL:
Does your skin appear fragile or burn easily? Y N If yes, explain: ___________________
Do you have any problems healing from a cut or burn? Y N If yes, explain: ___________________
Do you have any health problems? Y N If yes, explain: ___________________
Do you ever use depilatories or waxes on your face? Y N If yes, when last used?
____
Have you ever had a "cold sore"? Y N
If yes, when was last cold sore? ___________

SUN HISTORY AND LIFESTYLE:
Do you work inside? Y N
Occupation: _______________
Are your hobbies done mostly outside? Y N Hobbies: _______________
In the past (including childhood) did you live in a sun belt? Y N where did you live? ________
In the past have you neglected to use a sunscreen when outdoors? Y N
Do you ever use tanning beds? Y N If yes, when? _____________
Do you currently wear a sun protection product all day, everyday? Y N
Are you willing to wear a sun protection product all day, everyday? Y N

HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD SKIN CANCER? Y N
If yes, who? ___________________________________ Anatomical location of the lesion(s): ________________
ARE YOU CURRENTLY SEEING A PHYSICIAN FOR ANY REASON? Y N
IF YES, PLEASE EXPLAIN ____

HOW DO YOU WANT TO IMPROVE YOUR SKIN?
1) ____
2) ____

SKIN CONDITION: OS/A S/IS D/SDS PAS

WHAT SPECIFIC AREAS DO YOU WANT TO TREAT? NECK FACE OTHER
CHEST BACK

DO YOU WEAR CONTACT LENSES? Y N

PATIENT SIGNATURE:	DATE:
TECHNICIAN SIGNATURE:	DATE: