



Medical History Questionnaire

What type of problem are you consulting for? \_\_\_\_\_  
\_\_\_\_\_

**Personal Information:**

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_ (\_\_\_\_) \_\_\_\_\_ Cell Phone \_\_ (\_\_\_\_) \_\_\_\_\_

Work Phone \_\_ (\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_ @ \_\_\_\_\_

**Preferred contact number & best time to call**

\_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

**Emergency Contact Name/Phone Number** \_\_\_\_\_

How did you hear about us? Radio \_\_\_ Magazine \_\_\_ Newspaper \_\_\_ Friend \_\_\_ Walk-in \_\_\_

Other (please specify) \_\_\_\_\_  
\_\_\_\_\_

**Health Information**

**General:**

Age \_\_\_\_\_ Current Weight lbs \_\_\_\_\_ Height \_\_\_\_\_ BMI \_\_\_\_\_

Date of last physical \_\_\_\_\_ Name of Family Physician \_\_\_\_\_

Is your general health good? Yes \_\_\_ No \_\_\_ if "No", explain \_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies to medications, latex, soy, or anesthesia? If yes, please specify and state type of reaction: \_\_\_\_\_

List all medications (oral, topical) & herbal supplements you are taking (prescription and OTC) \_\_\_\_\_

Do you take Aspirin, Advil, Motrin, Ibuprofen, or anti-inflammatory medication more than once a week? If yes please explain. \_\_\_\_\_

Do you smoke? If yes, how many per day for how many years? \_\_\_\_\_

Do you drink alcohol? If yes, how much and how often? \_\_\_\_\_

Are you pregnant, nursing or planning a pregnancy soon? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, how soon? \_\_\_\_\_

Mark your skin type (when exposed to the sun for about 1 hour with no protection):

- ❖ Always burns, never tans
- ❖ Always burns, sometimes tans
- ❖ Sometimes burns, sometimes tans
- ❖ Always tans
- ❖ Asian, Hispanic, Mediterranean, Middle Eastern
- ❖ Black

When were you last exposed to the sun (or a tanning booth)? \_\_\_\_\_

Do you use self tanning lotions?                    \_\_\_ Yes                    \_\_\_ No

Are you planning a holiday in the sun?                    \_\_\_ Yes                    \_\_\_ No

Have you ever had skin resurfacing, rejuvenation or chemical peels? \_\_\_ Yes                    \_\_\_ No

Have you ever had treatments for pigmented lesions? \_\_\_ Yes                    \_\_\_ No

Prior treatment (if any) \_\_\_\_\_

**Present/Past Medical History:**

Have you ever had any of the following (please circle)

- |                         |                        |                    |                      |
|-------------------------|------------------------|--------------------|----------------------|
| Asthma                  | Arthritis              | Anemia             | Cold sores           |
| Autoimmune disorder     | Blood disorder         | Chest pain         | Seizures             |
| Chronic diarrhea        | clotting disorder      | Colon problems     | Diabetes             |
| Depression              | Easy bruisability      | Excessive scarring | Excessive bleeding   |
| Heart valve replacement | Heart valve disease    | Heart attack       | Irregular heart beat |
| Heart failure           | Neuro-Muscular disease | Mental disease     | Liver disease        |
| High blood pressure     | Hepatitis              | HIV                | Thyroid disorder     |
| Intestinal problems     | Keloids                | Kidney disease     | Migraines            |
| Lung disease            | Stroke                 | Stomach problems   | Rheumatic fever      |
| Multiple Sclerosis      | Muscular dystrophy     | MVP                | Shortness of breath  |

Cancer-please list type \_\_\_\_\_

List all surgeries or hospitalizations with dates: \_\_\_\_\_

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Have you ever had any cosmetic procedures in the past? Please list with dates:

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**To the best of my knowledge, the information provided above is true and accurate,**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date \_\_\_\_\_

Review comments: \_\_\_\_\_

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Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Consultation Comments \_\_\_\_\_

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# Fitzpatrick Skin-type Chart

Please circle the answer to each question to determine your skin type.

Score	0	1	2	3	4
What color are your eyes?	Light blue, gray, green	Blue gray, green	Blue	Dark Brown	Brown Black
What is your natural hair color	Sandy red	Blonde	Dark blonde, chestnut brown	Dark brown	Black
What is your skin color? (non-exposed areas)	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
Do you have freckles ins the non-exposed areas?	Many	Several	Few	Incidental	None
What happens when you stay in the sun too long?	Redness, pain, blistering, peeling	Burns followed by peeling	Burns some-times followed by peeling	Rarely burns	Never has a burn
To what degree do you turn brown?	Hardly at all	Light tan color	Reasonable tan	Tan very easy	Turn dark brown
Do you turn brown within several hours after sun exposure?	Hardly or not at all	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never has a problem
When did you last expose your body to the sun or tanning bed?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
Did you expose the area you want treatment to the sun?	Never	Hardly ever	Sometimes	Often	Always

Total Score	Fitzpatrick Type
0-7	1
8-16	2
17-25	3
26-30	4
Over 30	5

Please read carefully and sign your acknowledgement of our refund and cancellation policies. It is our desire to give our clients the best possible service and when we have cancellations without notice, we are left with time slots that could have been filled by other clients. Thank you for your cooperation in this matter!

## REFUND POLICY

All sales, services, down-payments are **NON-REFUNDABLE**. You may transfer your monies to other services; however there will be no refund.

## Cancellation Policy

We require a 24-HOUR NOTICE if you are going to change your appointment. For changes made with less than a 24-HOUR notice, 50% of the cost of the procedure will be charged to your Credit Card; or if the services are prepaid, we will deduct 50% of the cost of the procedure from your credit balance.

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Client Signature

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Date