Name:_____ DOB:____/_____/_____ Date:_____/_____/_____

Are you pregnant? Y__ N__ Are you nursing? Y__ N__ Are you planning on becoming pregnant? Y__N__

Are you currently taking ACCUTANE or have you taken this in the last 6 months? Y__ N__

Past Personal Medical History: (please circle all that apply)

Anemia
Cold Sores
Pacemaker/Defibrillator
Bleeding Disorder
Dialysis
High Blood Pressure
Metal Implants
Disease
Chronic Cough
Irregular Heartbeat
Stroke
Diabetes
Hepatitis B or C
Valley Fever
Burns
Cancer
Heart Murmur
Seizure Disorder
Autoimmune Disease
Herpes Simplex
Ulcers
Bronchitis
Heart Disease
Multiple Sclerosis
Phlebitis
Artificial Joint
Connective Tissue Disorder
Tuberculosis
Breast Cancer
Fibromyalgia
Migraines
Mechanical Heart Valve
Arthritis
Colitis
Thyroid Disorder
Blood Clots
Depression
HIV/AIDS
Raynaud's

Past Personal Skin History: (please circle all that apply)

Undiagnosed Skin Lesions
Actinic Keratosis
Squamous Cell Skin Cancer
Connective Tissue Disorder
Serious Skin Infection
Lupus
Melanoma
Psoriasis
Pigment Disorder
Shingles
Eczema
Keloid Scars
Basal Cell Skin Cancer

Have you ever seen a dermatologist or plastic surgeon for your skin? Y__ N__

If yes, explain:_____

Family History: (please circle all that apply)

Adopted
Cancer
Diabetes
Melanoma
Heart Disease
Stroke
Autoimmune Disorders
High Blood Pressure
Skin Disease

Review of Systems: (please circle) Do you currently have any of the following symptoms:

Poor General Heath
Swollen Lymph Nodes
Easy Bruising
Headache
Chest Pain
Swelling
Suspicious Moles
Swollen Legs/Feet
Heat/Cold Intolerance
Flushing
Itching
Rashes
Bleeding Tendencies
Circulation Problems
Non-healing Sores
Fainting
Numbness

Medication Allergy and Reaction

_____

_____

Latex allergy? Y___N___ Iodine allergy? Y____ N____

Previous Surgeries?

_____

_____

Other:_____ _____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

_____ _____

Client Signature: Date

_____ _____

Reviewed by: Date