

NEW CLIENT – MEDICAL HISTORY & SKIN CONSULTATION INFORMATION

CLIENT NAME: _____

MEDICAL HISTORY

1. Please list any drug allergies or sensitivity: _____

2. Have you ever used/are you currently using any of the following? (check all that apply)
____ Retin A ____ Renova ____ Accutane ____ Prescription Acne Medicine
____ Steroids ____ Birth Control Pills ____ Depo Shot
3. Please list all prescription and non-prescription medication or herbal supplements that you are currently taking: _____

4. Women, Are you pregnant or breast-feeding? ____ Yes ____ No
5. Please list any chronic conditions that are currently treated by your primary care provider: _____
6. Please list any past hospitalizations or surgeries: _____

7. Please list any past cosmetic facial treatments or facial surgeries and any complications or reactions _____
8. Have you ever had or been treated for: (check all that apply)

<input type="checkbox"/> Cancer	<input type="checkbox"/> Headaches/Migraine	<input type="checkbox"/> Multiple Scelosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Muscle Problems
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Nerve Injury
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mental Disease	<input type="checkbox"/> Skin Rash/Disease
<input type="checkbox"/> Head Injury		
9. Do you smoke? ____ No ____ < 1 pack per day ____ 1 pack or more per day
10. Have you ever had cold sores or fever blisters? ____ Yes How Often? _____
11. How often do you suntan? _____

Form continued on back

