

# Cosmetic Medical History

Name \_\_\_\_\_ Who referred you to us? \_\_\_\_\_

Date of Birth \_\_\_\_\_ Date of Visit \_\_\_\_\_

Please circle your cosmetic concerns:

Sun spots / Age Spots	Wrinkles	Birthmarks- Brown/Red
Spider veins	Telangiectasia	Red spots- cherry angiomas
Hyperpigmentation	Rosacea	Port wine stains
Acne Scars	Large pores	Actinic Keratoses / Precancers
Surgical scars	Hypertrophic scars	Laser Hair removal
Sagging Skin	Lines around mouth/eyes	Discuss Skin care regimen

Have you ever been treated for this problem?  Yes  No

If yes, when? \_\_\_\_\_ By what method? \_\_\_\_\_

Are you currently taking/using medication for your skin problem?  Yes  No

If yes, which medication? \_\_\_\_\_

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

If yes, when? \_\_\_\_\_

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

Do you have a history of keloid scarring/ excessive scarring?  Yes  No

Do you have a history of:

- |   |   |
|---|---|
| <input type="checkbox"/> Heart disease                    | <input type="checkbox"/> Radiation treatment                      |
| <input type="checkbox"/> Herpes sores                     | <input type="checkbox"/> Bruising/Bleeding disorders              |
| <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Accutane treatment                       |
| <input type="checkbox"/> Skin cancer, or suspicious moles | <input type="checkbox"/> Darkening of facial skin after pregnancy |

Have you ever had an allergic reaction to anesthesia/injections?  Yes  No

Do you have any skin related allergies?  Yes  No

If yes, please specify \_\_\_\_\_

Do you have any allergies to medication?  Yes  No

If yes, please specify \_\_\_\_\_

Do you take any of the following medications?

- |  |   |
|--|---|
| <input type="checkbox"/> Aspirin                 | <input type="checkbox"/> Anti-coagulants (blood thinners) |
| <input type="checkbox"/> Hormones/contraceptives | <input type="checkbox"/> Cortisone/Prednisone             |
| <input type="checkbox"/> Thyroid medication      | <input type="checkbox"/> Insulin                          |
| <input type="checkbox"/> Sedatives               | <input type="checkbox"/> Tranquilizers                    |
| <input type="checkbox"/> Multi-Vitamin           |   |

Are you taking any herbal preparations? (St. John's Wort)  Yes  No

If yes, list \_\_\_\_\_

What is your daily consumption of alcohol? \_\_\_\_\_

Do you wear contact lenses?  Yes  No

Have you ever had cold sores or fever blisters?  Yes  No

When was last breakout? \_\_\_\_\_

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

- |     |  |                          |
|-----|--|--------------------------|
| I   | Always burns, never tans                       | <input type="checkbox"/> |
| II  | Always burns, sometimes tans                   | <input type="checkbox"/> |
| III | Sometimes burns, sometimes tans                | <input type="checkbox"/> |
| IV  | Always tans                                    | <input type="checkbox"/> |
| V   | Asian, Hispanic, Mediterranean, Middle Eastern | <input type="checkbox"/> |
| VI  | Black  | <input type="checkbox"/> |

When did you last get a tan? \_\_\_\_\_

Do you use chemical (sunless) sun tanning lotions?  Yes  No

Are you planning a holiday in the sun?  Yes  No

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

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