skin renew

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MEDICAL HISTORY FORM

Patient Name_____ Date_____

Date of Birth_____ Sex _____M _____F Age_____ Height_____ Weight_____

General Medical History: Do you or have you ever had any of the following problems? *Circle **Y** for Yes and **N** for No*

Bronchitis	Y	N	Diabetes	Y	N
Emphysema	Y	N	Thyroid	Y	N
Asthma	Y	N	Herpes - Mouth	Y	N
Kidney or Bladder	Y	N	Herpes - Genital	Y	N
Chronic Cough	Y	N	Basal or Squamas Cell	Y	N
Morning Cough	Y	N	Cancer	Y	N
Shortness of Breath	Y	N	Melanoma	Y	N
Wheezing	Y	N	Arthritis / Joint Deformity	Y	N
High Blood Pressure	Y	N	Fainting	Y	N
Blood Clot	Y	N	Convulsions, Epilepsy, or Seizures	Y	N
Chest Pain	Y	N	Rosacea or Acne	Y	N
Pacemaker / Defibrillator	Y	N	Thinning Lashes	Y	N
Heart Attack	Y	N	Onychomycosis / Toe Nail Fungus	Y	N
Heart Murmur	Y	N	Are you Pregnant or Breast Feeding	Y	N
Irregular Heartbeat	Y	N	Are you planning on being Pregnant	Y	N
Phlebitis	Y	N	Ingrown Hairs	Y	N
Inflammation of Veins	Y	N	Irritation from Shaving	Y	N
HIV or AIDS	Y	N	What is your current method of Hair Removal?		

Current and/or Recent Medications: _____

_____

Allergies to Medications: _____

Prior Cosmetic Procedures: *Circle **Y** for Yes and **N** for No*

Botox	Y	N	Microdermabrasion	Y	N
Fillers (Juvederm, Collagen, Etc)	Y	N	Intense Pulse Light Rejuvenation	Y	N
Laser Resurfacing	Y	N	Laser Hair Removal	Y	N
Chemical Peels	Y	N	Laser Vein Treatment	Y	N

Please **Circle** the procedures that you would like more information on: ***Laser Hair Removal*** ***Dermal Fillers*** ***Botox*** ***Laser Skin Resurfacing*** ***Brown Spots / Sun Damage*** ***Skincare Products*** ***Chemical Peels*** ***Microdermabrasion*** ***Acne Treatments*** ***Fat Reduction*** ***Onychomycosis / Nail Fungus***

Use of RetinA or topical Retinoids?	Y	N	Are you currently using Accutane?	Y	N
History of Use of Accutane?	Y	N	Do you routinely use Sunscreens? *Which SPF?* ____	Y	N

Social History:

Do you Smoke or use Tobacco?	Y	N	Do you drink Alcohol? *# per Day_____, # per Week_____, or # per Year_____*	Y	N

Marital Status: _____ Children: _____ Hobbies: _____ Occupation: _____

What type of Skincare products do you currently use for your face and body? _____

Are you currently under the care of a Dermatologist? Y or N If Yes, why? _____

PATIENT SIGNATURE: _____ **DATE:** _____

REVIEWED BY: _____ **DATE:** _____