SKINWERX

Health History Questionnaire

GENERAL INFORMATION:

Full Name: ______________________ Sex: ◯ Female ◯ Male

Date of Birth: __________ Age: ______ Height: ______ Weight: ______

Occupation: __________ Employer: __________ Type of Work: __________

Marital Status: ◯ Married ◯ Divorced ◯ Single ◯ Widowed ◯ Seperated ◯ __________

Children's Name: ______________________ Age: ______

Children's Name: ______________________ Age: ______

Children's Name: ______________________ Age: ______

PERSONAL MEDICAL HISTORY (Please check all that apply)

- ☐ Asthma / COPD / Bronchitis
- ☐ Acne / Accutane
- ☐ Anxiety / Depression
- ☐ Cancer (type __________)
- ☐ Cholesterol / Triglyceride's (high)
- ☐ Chronic Fatigue Syndrome / Fibromyalgia
- ☐ Colitis / Crohn's Disease / Ulcers
- ☐ Diabetes (◯ Type 1 ◯ Type 2)
- ☐ Eczema / Psoriasis / Melasma
- ☐ Epilepsy / Seizures
- ☐ Headaches / Migraines
- ☐ Heart Disease / MI / ACS
- ☐ Hepatitis (◯ A ◯ B ◯ C)
- ☐ Herpes / Cold Sores
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Melanoma
- ☐ Menopause
- ☐ Neurological Disorder
  - ☐ Multiple Sclerosis
  - ☐ Guillain-Barre
  - ☐ Lambert-Eaton
- ☐ Pacemaker / Irregular Heart Beat
- ☐ Polycystic Ovarian Disease / Hirsutism
- ☐ Raynaud's Disease / Poor Circulation
- ☐ Rheumatoid Arthritis / Arthritis
- ☐ Autoimmune Disease / Lupus
- ☐ Syncope (fainting) / Low Blood Pressure
- ☐ Thyroid (◯ Low or ◯ High)
- ☐ TMJ
- ☐ Other __________
- ☐ Other __________

MEDICATIONS (Please list all including topical prescription products, over the counter, supplements, herbs, etc)

Name	Dose	Frequency	Reason for Use

In the last 12 months, have you experienced: ☐ Weight Gain? ☐ Weight Loss? Amount? ______ lbs.

Any significant current illnesses? ______________________

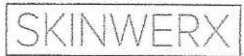
Do you experience complications with: ☐ Healing ☐ Bleeding ☐ Bruising ☐ Healing

Metal Implants in Body? Type and location: ______________________ ☐ Pacemaker ☐ Defibrillator

ALLERGIES (medication, food, contact allergies)

____

Personal Physician: ______________________ ☐ MD ☐ DO ☐ ND ☐ Other



NON-COSMETIC SURGERIES (Please provide Year, Physician Name, and Type of Surgery)

____

Have you ever experienced an adverse reaction to a *cosmetic* or *laser procedure*? ◯ Yes ◯ No

If yes, please describe: ______________________________

COSMETIC SURGERIES OR TREATMENTS

Procedure	Date	Physician/Location	Satisfaction (0-5)

FAMILY HISTORY (Please check all that apply)

- ☐ Skin Cancer and Melanoma
- ☐ Blood Disorder / Anemia
- ☐ Cancer (Type: ____________)
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol / Triglycerides
- ☐ Psychiatric Disorder
- ☐ Thyroid Disease
- ☐ Obesity
- ☐ Other ____________

SOCIAL BACKGROUND & HABITS

Exercise (type and frequency): ______________________________

Alcohol? Number of drinks consumed per week: ____________

Tobacco? ◯ No ◯ Yes ☐ Cigarettes / Packs per day: ____________ Quit Date: ____________

Tanning Habits: ☐ Tanning Bed ☐ Self Tanner ☐ Spray Tan ☐ Natural Tan Frequency? ________

FEMALE PATIENTS

Are you currently pregnant? ◯ Yes ◯ No Are you currently breast feeding ◯ Yes ◯ No

Are you planning to become pregnant during the course of your treatment? ◯ Yes ◯ No

Agreement to Proceed with Treatment:

Although extremely rare, your treatment might result in the need for medical follow-up. We want you to report any concerns about your treatment to us immediately and if indicated, we will ask you to come to our office within 48 hours to be seen. We will instruct you to adhere to our recommended treatment plan for your follow-up care, provided at no charge to you. These visits will include clinical photography. You may choose to receive medical care elsewhere (e.g; your primary care physician) as well, but this will not replace the care you receive at the practice, & agree to release those medical records to the practice if requested.

I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold the doctor, or any other member of the staff, responsible for any errors or omissions that I may have made in completion of this form.

Patient Signature: ______________________________ Date: ____________

Treatment Provider Signature: ______________________________ Date: ____________

MD Signature: ______________________________ Date: ____________

IN OFFICE USE ONLY

Reviewed with patient by: ____________ Date: ____________

Reviewed with patient by: ____________ Date: ____________

NEW PATIENT INFORMATION FORM AND CLEARANCE FOR PROCEDURES

Please fill out to dotted line

____

NAME **DATE OF BIRTH**

____

ADDRESS

____

EMAIL

____

PHONE

____

HOW DID YOU HEAR ABOUT US?

______________Patient is cleared for ALL procedures at Skinwerx

______________Patient is cleared for procedures at Skinwerx with the exception of those listed below:

____

____

____

______________NOT CLEARED for any procedures at Skinwerx

____

Medical Screen Provider Name **Date**