

HISTORY

Name _____ Sex: M F

DOB _____ Age _____ Date _____

Allergies/Adverse Reactions/Skin Sensitivities–Allergy: **Latex** Yes No **Nickel** Yes No
Other: List _____

Current Medications, Vitamins, Herbs, Supplements, Over-The-Counter Mediations

Have you ever taken Acutane? Yes No When last taken? _____

Do you have any of these conditions?

- | | | |
|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Arthritis</u> | Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Asthma</u> | Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Bleeding Disorder</u> |
| Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Cancer</u> | Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Diabetes - <input type="checkbox"/> insulin</u> | Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Epilepsy</u> |
| Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Depression</u> | Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Heart Disease</u> | Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Pacemaker/Defibrillator</u> |
| Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Hepatitis</u> | Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Hormonal Disorder</u> | Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Hypertension</u> |
| Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Kidney disease</u> | Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Muscle condition</u> | Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Hepatitis, HIV, AIDS</u> |
| Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Neck pain/TMJ</u> | Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Seizures/Stroke</u> | Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Smoking</u> |
| Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Substance Use</u> | Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Thyroid</u> | Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Thrombosis/Phlebitis</u> |
| IF FEMALE: <input type="checkbox"/> <u>Not Pregnant</u> | Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Breast feeding</u> | Yes <input type="checkbox"/> No <input type="checkbox"/> <u>Permanent makeup/tattoo</u> |
- Other: _____

Have you ever had?

- Yes No Facial filler injections – Silicone, Restylane® etc. _____ most recent date
 Yes No Botox _____ most recent date
 Yes No Facial implants Yes No Cold sores do you want medication ordered to help prevent a cold sore incident? Yes No Pharmacy _____

Do you have dental crowns, caps, braces or other metal dental implants No Yes _____

How does your skin respond to sun exposure without protection? Please check.

- Always burn easily, skin never tans, very sun sensitive skin, ethnicity includes northern Europeans
- Usually burn easily, tans sometimes, ethnicity includes a mix of northern European and others
- Sometimes burns, tans gradually to light brown, ethnicity includes mix of northern Europeans and others
- Hardly ever burns, tans easily and quickly to a dark color, ethnicity includes Mediterranean, Latino, Asian and Middle Eastern, Native American
- Never burns, skin is naturally dark ethnicity includes African American

When were you last exposed to the sun including a tanning booth? _____

Are you planning to be in the sun including a tanning booth in the near future? Yes No

If yes, describe _____ Do you use self tanners? Yes No

Do you hyper-pigment (develop a darker area) after an injury? Yes No

Do you heal well/easily after a cut or burn? Do you form keloids (scars) Yes No