



In-take Practitioner: \_\_\_\_\_  
Date: \_\_\_\_\_

## HEALTH HISTORY QUESTIONNAIRE

<b>Name</b> <i>(Last, First, M.I.):</i> _____	<input type="checkbox"/> M	<input type="checkbox"/> F	<b>DOB:</b> _____
<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
<b>Previous or referring doctor:</b> _____		<b>Date of last physical exam:</b> _____	

### PERSONAL HEALTH HISTORY

**List any medical problems that have been diagnosed:**

**Surgeries:**

Year	Reason	

**Other hospitalizations:**

Year	Reason	

**List your prescribed drugs and over-the-counter drugs, such as vitamins and supplements**

Name the Drug/Vitamin/Supplement	Strength	Frequency Taken

**Allergies to medication, topical skin products or solutions or food**

Item	Reaction You Had

**Have you ever had seizures or diagnosed with a seizure type illness?**       Yes     No

### ABOUT YOUR SKIN, HEALTH HABITS & HISTORY

<b>Have you ever had?</b> <i>(dates please):</i>	<input type="checkbox"/> Plastic Surgery    Date: _____	<input type="checkbox"/> Fillers (Juvederm, Restylane, Radiesse)    Date: _____
	<input type="checkbox"/> Chemical Peel    Date: _____	<input type="checkbox"/> Facial Implants    Date: _____
	<input type="checkbox"/> Microderm    Date: _____	<input type="checkbox"/> Facial Reconstruction/Plating/Injury    Date: _____
	<input type="checkbox"/> Botox/Dysport    Date: _____	<input type="checkbox"/> Other: _____    Date: _____
<b>Have you ever used:</b>	<input type="checkbox"/> Retin A <input type="checkbox"/> Hydroquinone <input type="checkbox"/> Skin Bleachers	
	<input type="checkbox"/> Glycolic Acid <input type="checkbox"/> Accutane <input type="checkbox"/> Salicylic Acid	
	<input type="checkbox"/> Valtrax <input type="checkbox"/> Vaniqua <input type="checkbox"/> Other Professional/Medical Skin Care Grade Products: _____	

**Do you get cold sores?** (If YES, Please list date of last outbreak) \_\_\_\_\_ Medication Used: \_\_\_\_\_       Yes     No

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.



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<b>Do you smoke?</b> (If YES, packs per <i>day</i> : _____)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Drink Caffeine?</b> (If YES, drinks per <i>day</i> : _____)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Drink Alcohol?</b> (If YES, drinks per <i>week</i> : _____)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Drink Water?</b> <input type="checkbox"/> NONE <input type="checkbox"/> 1-2 Glasses per day <input type="checkbox"/> 3-4 glasses per day <input type="checkbox"/> 5+ glasses per day		

**ABOUT YOUR LIFESTYLE:**

<b>About Your Activities?</b>	<input type="checkbox"/> Play Outdoor Sports?	<input type="checkbox"/> Sunbathe?	<input type="checkbox"/> Spend Time at Beach/Pool?
	<input type="checkbox"/> Garden?	<input type="checkbox"/> Visit Tanning Beds?	<input type="checkbox"/> Swim?
	<input type="checkbox"/> Work Outdoors?	<input type="checkbox"/> Go Boating?	<input type="checkbox"/> Exercise? Strength Train/Cardio Train/Both

**CURRENT SKIN CARE REGIMEN/ROUTINE**

<b>AM ROUTINE:</b>	
<b>PM ROUTINE:</b>	

<b>Current Skin Product Line?</b>		
<b>Current Skin Makeup Line?</b>		
<b>Do you use a daily SPF?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Do you use an SPF when outdoors?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Do you wax, thread, or tweeze your facial hair?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>How would you classify your skin?</b> <input type="checkbox"/> Oily <input type="checkbox"/> Dry <input type="checkbox"/> Combination		
<b>Do you consider your skin?</b> <input type="checkbox"/> Sensitive <input type="checkbox"/> Resilient <input type="checkbox"/> Unsure		

<b>Describe your skin concerns?</b> (Check all that apply):	<input type="checkbox"/> Acne Scars	<input type="checkbox"/> Lines and Wrinkles	<input type="checkbox"/> "Sad Mouth" Parentheses around mouth
	<input type="checkbox"/> Adult Onset Acne	<input type="checkbox"/> Brown Spots	<input type="checkbox"/> Large Pores
	<input type="checkbox"/> Oily Skin No Acne	<input type="checkbox"/> Frown Lines	<input type="checkbox"/> Sun damaged FACE/HANDS
	<input type="checkbox"/> Dry Skin with Acne	<input type="checkbox"/> Redness	<input type="checkbox"/> Excema
	<input type="checkbox"/> Rosacea	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Spider Veins LEGS/FACE

**WHAT CHANGES WOULD YOU LIKE TO SEE IN YOUR SKIN?**


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

Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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