aboutface SKIN CARE

In-take Practitioner:_____
Date:_____

HEALTH HISTORY QUESTIONNAIRE

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

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

Have you ever had? **(dates please):**	☐ Plastic Surgery	Date:_____	☐ Fillers (Juvederm, Restylane, Radiesse)	Date:_____
	☐ Chemical Peel	Date:_____	☐ Facial Implants	Date:_____
	☐ Microderm	Date:_____	☐ Facial Reconstruction/Plating/Injury	Date:_____
	☐ Botox/Dysport	Date:_____	☐ Other:_____	Date:_____
Have you ever used:	☐ Retin A	☐ Hydroquinone	☐ Skin Bleachers	
	☐ Glycolic Acid	☐ Accutane	☐ Salicyclic Acid	
	☐ Valtrax	☐ Vaniqua	☐ 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.

TREATING AND DELEGATING PHYSICIAN: Dr. Tina Ann-Kerr Thompson

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Do you smoke? (If YES, packs per *day*:_____)	☐ Yes	☐ No
Drink Caffeine? (If YES, drinks per *day*:_____)	☐ Yes	☐ No
Drink Alcohol? (If YES, drinks per *week*:_____)	☐ Yes	☐ No
Drink Water? ☐ NONE ☐ 1-2 Glasses per day ☐ 3-4 glasses per day ☐ 5+ glasses per day		

ABOUT YOUR LIFESTYLE:

About Your Activities?	☐ Play Outdoor Sports?	☐ Sunbathe?	☐ Spend Time at Beach/Pool?
	☐ Garden?	☐ Visit Tanning Beds?	☐ Swim?
	☐ Work Outdoors?	☐ Go Boating?	☐ Exercise? Strength Train/Cardio Train/Both

CURRENT SKIN CARE REGIMEN/ROUTINE

AM ROUTINE:	
PM ROUTINE:	

Current Skin Product Line?		
Current Skin Makeup Line?		
Do you use a daily SPF?	☐ Yes	☐ No
Do you use an SPF when outdoors?	☐ Yes	☐ No
Do you wax, thread, or tweeze your facial hair?	☐ Yes	☐ No
How would you classify your skin? ☐ Oily ☐ Dry ☐ Combination		
Do you consider your skin? ☐ Sensitive ☐ Resilient ☐ Unsure		

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

WHAT CHANGES WOULD YOU LIKE TO SEE IN YOUR SKIN?

Patient Signature:_____ Date:_____

Clinician Signature:_____ Date:_____

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In-take Practitioner:_____
Date:_____

Patient Information **Today's Date_____**

First Name:_____ Last Name:_____

Email Address_____

Would you like to be notified via e-mail of your future appointments: ☐ Yes ☐ No (You may opt-out at any time)

Hm. Phone (_____)_____

Wk. Phone (_____) _____

Cell Phone (_____)_____

Preferred Number: ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth:_____ | ☐ MALE ☐ FEMALE | Occupation:_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Whom may we thank for referring you?

☐ Another Client:_____

☐ Print Media (circle one): Gwinnett Citizen OurTown Mag. Direct Mail Other:_____

☐ Internet Search/Site

Person to contact in case of emergency_____ Phone_____

Mailing Address:

Address:_____City:_____State:_____Zip_____

Shipping Address: (if different)

Address:_____City:_____State:_____Zip_____

If Under the age of 18,

Parent's Name:_____ Contact Phone_____

Would you like to receive our e-newsletter? ☐ Yes ☐ No (You may opt-out at any time)

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Cancellation Policy

Your appointment time is reserved exclusively for you. While we realize that unexpected situations may occur, your appointment is subject to a charge of $50 for your first no-show, or cancellation of less than 24 hours notice (48 hours for Friday and Saturday appointments). After the first time, there will be a charge of 50% of the scheduled service for less than 24 hours' notice of cancellation and up to 100% for any no-shows. Therefore, we may require the guarantee with a major credit card. This enables your service provider to receive his/her compensation for loss of time. If notification is not received within these requirements, a cancellation fee will be charged. To ensure all guests receive their full treatment, we will do our best to accommodate late arrivals, but we cannot guarantee service to guests arriving 15 or more minutes after their scheduled appointment time. Any late arrivals will be treated for the left over duration of the booked appointment time. We regret that late arrivals will not receive an extension of scheduled service times and will be responsible for full service fees, as a courtesy to our staff. This policy will also be effective for all gift card clients and series clients. If you have a series, the service from this series would be deducted. If you have a gift card, the balance of the procedure that you booked would be deducted from the gift card, as a courtesy to our staff.

_____

Client Printed Name

_____ **Date:_____**

Client Signature

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