

In-take Practitioner:	
Date:	

HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.	I.):				□ M □ F	DOB	<u> </u>				
Marital status:	☐ Single	□ Partnered	☐ Married	□ Separated	□ Divorced	□ Wi	dowed				
Previous or refe	rring doctor:				Date of last ph	nysical	exam:				
PERSONAL HEALTH HISTORY											
			PERS	MAL HEAL	III III JIOKI						
List any medical	problems that	have been diag	nosed:								
Surgeries:											
Year	Reason										
real	reason										
Other hospitaliz	ations:										
Year	Reason										
List your prescri					ns and supplem	<u>ents</u>	I				
Name the Drug/Vitamin/Supplement			Strength	Strength Frequency Taken							
									—		
Allergies to medication, topical skin products or solutions or food											
				You Had							
Have you ever had seizures or diagnosed with a seizure type illness?											
ABOUT YOUR SKIN, HEALTH HABITS & HISTORY											
	· · · · · · · · · · · · · · · · · · ·	I			□ Fillows (1,1,1,0)	dorm [Postulano Dadiosco)	Data			
(dates places)		☐ Plastic Surger	-		☐ Fillers (Juvederm, Restylane, Radiesse) ☐ Facial Implants			Date:			
		☐ Microderm			☐ Facial Reconstruction/Plating/Injury			Date:			
□ Botox/Dysport					☐ Other:						_
Have you ever	used:	□ Retin A		droquinone	☐ Skin Bleachers			_		_	
-		☐ Glycolic Acid	□ Ac	cutane	☐ Salicyclic Acid						
		□ Valtrax	□ Va	niqua	☐ Other Professional/Medical Skin Care Grade Products:						
Do you get cold	I sores? (If YES,	Please list date o	f last outbrea	ak)	Medication Us			□ Y	es		No

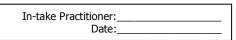
All questions contained in this questionnaire are strictly confidential



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Do you smoke? (If YES, packs per day:)											
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 Beac							n/Pc	ool?			
			☐ Garden? ☐ Visit Tanning Beds? ☐ Swim?								
☐ Work Outdoors? ☐ Go Boating? ☐ Exercise? Strength Ti								rain	/Cardio	Γrain/	'Both
CURRENT SKIN CAF	RE REGI	IMEN/ROU	TINE								
AM ROUTINE:	TE ITEO										
APPROOFINE.											
PM ROUTINE:											
Current Skin Product I	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 ☐ Acne Scars ☐ Lines and Wrinkles ☐ "Sad Mouth" Parentheses around mouth											
concerns? (Check all that apply): □ Adult Onset Ad			et Acne	☐ Brown Spots		☐ Large Pores					
□ Oily Skin No Acne □ Frown Lines				☐ Sun damaged FACE/HANDS							
□ Dry Skin with Acne □ Redness □ Excema				□ Excema							
☐ Rosacea ☐ Psoriasis ☐ Spider Veins				☐ Spider Veins LEGS	5/FACE						
		WHAT	CHANG	ES WOULD YOU	J LIKE	TO SEE IN YOU	R SKIN?				
Patient Signature: Date:											
Clinician Signature: Date:											

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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 l	Mail Other:		
☐ Internet Search/Site			
Person to contact in case of emergencyPhone			
Mailing Address:			
Address:State:Zij	p		
Shipping Address: (if different)			
Address:State:Zij	p		
If Under the age of 18,			
Parent's Name: Contact Phone	-		
Would you like to receive our e-newsletter? \(\subseteq \text{Yes} \subseteq \text{No} \) (You may opt-out at an	y 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	