Facial Cosmetic History

«lastname», «firstname» «prefix»
ID: «patientid» DOB: «birthday»

Please Briefly State Your Reason and Goals / Expectations Treatment :

_____

_____

Are you now or have you been under the care of a physician for your skin ? Yes No
List all skin related medications / products you are currently taking or have taken for your skin including *Acutane, Retin A, Glycolic Acid, alphahydroxy acids, and skin scubs or exfoliants:*

_____

_____

List any drug, makeup, skin or food allergies (i.e., soaps or cleansing creams):

_____

List all any previous skin peels, treatments, dermabrasions, facial cosmetic surgery of any type?

_____

_____

Do you have acne? Yes No Experience Frequent Blemishes? Yes No
If so, how frequently?_____

Are you pregnant? Yes No Are you taking birth control pills? Yes No Hormone replacement? Yes No
Are you presently having or due for your menstrual cycle? Yes No
Do you experience oily shine during the day? _____
Do you sunbathe or use tanning beds? Yes No
Do you burn easily in moderate sunlight? _____
Do you regularly use a sunscreen? Yes No If so, what SPF? ____
Do you often experience stress? Yes No
What temperature of water do you use to cleanse your face? ___ COOL ___ WARM ___ HOT
Do you exercise regularly? _____
Do you smoke? If so, how much? _____

What is you natural hair color? _____

Do you have or have you had any of the following conditions (answer Yes or No):

_____ Are you currently taking aspirin or ibuprofen or any other supplement of NSAIDS that may interrupt blood coagulation?
_____ Cold Sores, Herpes Simplex
_____ Pterygium
_____ Hemophilia
_____ Prolonged Bleeding
_____ Have you ever experienced hyperpigmentation from an injury?
_____ Keloid History
_____ Cataracts
_____ Glaucoma
_____ "Dry Eye"
_____ Corneal Abrasions
_____ Eye Surgery, Blepharoplasty (eyelid surgery)or Injury
_____ Visual Disturbances
_____ Do you wear contact lenses?
_____ Are you using eye drops or other ocular medications?

When was your last eye exam? ____/____/____

Date		Signature of Person Completing Health History	Doctor's Initials

No Changes

Date	Y N	Signature of Person Completing Health History	Doctor's Initiials
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Date	Y N	Signature of Person Completing Health History	Doctor's Initials