Patient Information Questionnaire

Today's Date: ___________________

Personal Information

Office Use Only __________ *DE*

Name ____ DOB: _______________________

Address: ____ Apt. #:_______________________

City:_________________________________ State: ______________________ Zip: ________________________

Cell Phone: (_____)_______________ Home Phone: (_____)_____________ Work Phone: (_____)___________

Email Address: _________________________________

Occupation: ___________________________________ Employer: ______________________________________

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Emergency Contact Name/Phone Number: ____

Reason for your visit:

____

General Health History

Date of last physical: __________________________ Name of Family Physician: _______________________________

Is your general health good? ☐ Yes ☐ No

Please explain if you answered No:____

Allergies? ☐ Yes ☐ No Known Drug Allergies

If yes, please list:

List all medications you are taking (prescription and OTC):

____

____

Have you ever seen a Dermatologist for any skin concerns? If yes, please explain why.

____

Are you currently under a Doctor's supervision for any reason/condition? __________________________________

Have you ever had surgery? _________________ If yes, please explain: ____________________________________

Do you frequently suffer from stress? ____________ Are you claustrophobic? __________

Do you smoke? _________________ If yes, how often? ___________________________

Do you drink alcohol? ____________ If yes, how often? ___________________________

Are you currently pregnant? ☐ Yes ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

Present/Past Medical History

Do you suffer from any of the following: (please circle)

Diabetes Thyroid Condition Frequent Headaches Osteoporosis Back Pain Disk Herniation

High Blood Pressure Epilepsy/Seizures Joint swelling Varicose Veins Arthritis Cancer HIV

Contagious diseases Numbness or stabbing pains Cardiac or circulatory problems Auto immune disease

Other: ____

Are you currently or ever have been undergoing chemotherapy or radiation? ____________________

Do you have any body implants (i.e. prosthesis/metal) ____________________

Any other medical condition? ____________________

Do you wear contacts? ________

Do you exercise regularly? ________

Do you have a tendency to scar? ____________ Do you bruise easily? ____________

For Woman Only: circle any that apply

Regular Menstruation Hormonal Problems Menopause Birth Control Pill IUD (copper or plastic)

List all surgeries or hospitalizations with dates:

____________________________________ Date ____________

____________________________________ Date ____________

____________________________________ Date ____________

Present/Past Skin History

Do you sunbathe or participate in outdoor activities? ____________________

Do you tan in tanning booths? ____________ If yes, how often? ____________

When exposed to sun do you:

Burn Easily Tan Easily Never Burn Never Tan

Have you had any of the following skin conditions? If yes, please circle:

herpes (cold sores) keloids/excess scarring easy bruising eczema skin cancer

Acne & Skin Renewal Treatments

Have you had any of the following treatments in the past <u>6 months</u>?

Facial Cosmetic Surgery Permanent Cosmetics (tattoo) BOTOX Injections Laser Hair Removal

Collagen Injections Radio Frequency Treatment Dermal Filler Fractional Laser Resurfacing

Please list any cosmetic procedures you've had (surgical and non-surgical, including facial/brow tattoos and microblading) with dates:

____________________________________ Date ____________

____________________________________ Date ____________

____________________________________ Date ____________

Home Skin Care Products

What skin care products have you used recently at home?____________________

____

Have you ever used the following products?

	Currently Using	Used in the Past
Benzoyl Peroxide	______________	______________
Glycolic Acid	______________	______________
Lactic Acid	______________	______________
Salicylic Acid	______________	______________
Retin A	______________	______________
Vitamin C	______________	______________
Hydrocortisone	______________	______________
Hydroquinone	______________	______________
Differin (adapalene)	______________	______________
Azelex (azelaic acid)	______________	______________
Accutane (isotretinoin)	______________	______________

Any known side effects to the above products?

____

If today's visit is concerning skin treatments:

Is there any other necessary information your skin specialist should know before beginning your treatments?

____

____

How did you hear about us? ____

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge. I agree to tell the staff of any changes to my health history or medications as they arise. I understand that information is necessary for your practice and will remain confidential. All efforts are routinely made to ensure privacy is upheld.

______________________________ ______________________________

Printed Patient Name **Signature of Patient/Personal Representative**

______________________________ ______________________________

Relationship to Patient **Date**

______________________________ ______________________________

ALC Medspa Representative Name **Signature of ALC Medspa Representative**