a healthy skin experience

# Patient Profile

Name _____ Date _____

## Medical History

**Do you or have you ever had any of the following conditions? Check all that apply:**

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Auto Immune Deficiency
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer (chemo/radio therapy)
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy/Seizures
- ☐ Eczema
- ☐ Fainting
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Infection (active)
- ☐ Keloid/Hypertorphic Scars
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Melanoma (if yes list date/area) _____
- ☐ Mental Disorder
- ☐ Neuromuscular Disorder
- ☐ Nervous Disorder
- ☐ Photosensitive Conditions
- ☐ Pigmentation Disorder
- ☐ Porphyria
- ☐ Psoriasis
- ☐ Respiratory Issues
- ☐ Skin Disease (if yes, list type)_____
- ☐ Skin Cancer(if yes list date/area) _____
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease

**List all medications you are currently taking, oral and/or topical (including aspirins):**

_____

_____

_____

**Have you ever had:**

Cold Sores/Herpes/Fever Blisters/Shingles YES NO

*If YES, frequency: < 1/year 1-3/year 3-5+/year*

**Allergies:** ☐ Milk ☐ Aspirin ☐ Strawberries ☐ Sugar Cane ☐ Nickel

Medication Allergies: _____

Cosmetic Allergies: _____

Latex/Other Allergies: _____

**Have you ever or are you currently using:**

| | | |
|---|---|---|
| Retin-A, Renova, Retinoic Acid Products | YES | NO |
| Roaccutane (Accutane), Isotretinoin, Sotret, Claravis, Amnesteem, Absorica, Epuris, Isotroin | YES | NO |
| Prescription Acne Medication | YES | NO |
| Birth Control Pills | YES | NO |
| Steroids | YES | NO |
| Chemotherapy | YES | NO |
| Radiation Treatment | YES | NO |
| Pacemaker/Internal Defibrillator | YES | NO |

**Previous Procedures (if YES list date/area):**

| | | |
|---|---|---|
| Chemical Peel | YES | NO |
| Superficial Metal or other Implants | YES | NO |
| Injectables/Fillers | YES | NO |
| Tattoo/Permanent Makeup | YES | NO |
| Waxing/Hair Removal | YES | NO |
| Facial Surgery | YES | NO |
| Laser Surgery | YES | NO |
| Microdermabrasion | YES | NO |
| Lesion/Mole Removal | YES | NO |

**Are you currently:**

| | | |
|---|---|---|
| Pregnant (due date if you are_____) | YES | NO |
| Trying to become pregnant | YES | NO |
| Breastfeeding | YES | NO |
| Taking Aspirin or Blood Thinners | YES | NO |
| Tan/Using Self Tanner | YES | NO |

**Are you currently using/used in the last 3 months, any of the following?**

☐ St. John's Wart ☐ Anticoagulants ☐ Oral or Topical Retinoids (e.g. Roaccutane or Retin A)

☐ Amiodarone ☐ Gold Medications ☐ Oral or Topical Steroids

☐ Tetracycline Antibiotics

## Sun History & Lifestyle

How often do you work outdoors? ☐ Frequently ☐ Occasionally ☐ Very Rarely ☐ Never

How often do you use a sunscreen? ☐ Frequently ☐ Occasionally ☐ Very Rarely ☐ Never

How often do you use tanning beds? ☐ Frequently ☐ Occasionally ☐ Very Rarely ☐ Never

How often do you smoke or use tobacco? ☐ Frequently ☐ Occasionally ☐ Very Rarely ☐ Never

## Home Skin Care Regimen
## (please indicate if used more than once a day)

| | | | |
|---|---|---|---|
| Brand of Cleanser | | Brand of Toner | |
| Brand of Moisturizer | | Brand of Eye Cream | |
| Brand of Exfoliator | | Brand of Sunscreen | |
| Brand of Makeup | | Other | |