

Confidential Patient Information

- **Date**
 Date Format: MM slash DD slash YYYY
- **Name***
Patient's Full Name
 First Last
- **Address**
 Street Address Address Line 2 City State /
Province / Region ZIP / Postal Code Country
- **Email***
- **Daytime Phone***
- **Cell Phone**
- **Occupation**
Patient's Occupation
- **Dermatologist**
- **Dermatologist's Phone**
- **Physician**
- **Physician's Phone**
- **Emergency Contact**

Todd Doe

- Emergency Contact's Phone

7579873457

- Referred by:

- ☐ Friend
- ☐ Newspaper Advertisement
- ☐ Mailer/Insert
- ☐ Internet Search
- ☒ Other

- Is this your first facial?

- ☐ Yes
- ☒ No

- When was your last facial?

1month

- Is this your first body treatment?

- ☐ Yes
- ☐ No

- What is the reason for your visit today?*

Oily skin, breakouts on face and neck, Coarse hair g
and texture issues on face and neck

- What special concerns do you have?

everything

- Are you currently under a physician's care for any skin conditions?*

- ☒ Yes
- ☐ No

- What condition specifically?

rosacea

- How long have you had this skin condition?

8 months

- Have you had a recent operation?*

Select "No" if operation was more than two years ago.

- ☒ Yes
- ☐ No

- Please describe your operation:

Gall Bladder

- Were any medications prescribed?

- ☒ Yes
- ☐ No

- Are you still on medication?*

- ☒ Yes

☐ No

• What kind of medication are you on?

steroids

• What is the dosage?

• Is the area of the operation still sensitive to different temperatures or amounts of pressure?

☒ Yes

☐ No

• What is the date of your last gynecological visit?

07/12.19

Date Format: MM slash DD slash YYYY

• Which of the following procedures/exams did you have on your last visit?

☐ Pap smear

☒ Breast exam

☐ Mammogram

☐ Menstrual cycle

• Are you pregnant?*

☐ Yes

☒ No

• Are you (will you be) nursing?

☐ Yes

☒ No

• Are you taking birth control?*

☐ Yes

☒ No

• Are you on hormone replacement therapy?*

☐ Yes

☐ ☒ No

• Have you had any problems with moisture loss/becoming drier in any areas?

☐ ☒ Yes

☐ ☐ No

• Date of last dental exam:

01/12/19

Date Format: MM slash DD slash YYYY

• Were dental x-rays required?

☐ ☒ Yes

☐ ☐ No

• Do you wear contact lenses?

☐ ☒ Yes

☐ ☐ No

• Do you smoke?*

☐ ☒ Yes

☐ ☐ No

☐ ☐ I quit

• How much and how often?

10

• Do you normally smoke:

☐ ☒ Inside

☐ ☐ Outside

• How often are you around it?

Daily

• Do you have difficulty managing stress?

☐ ☒ Yes

☐ ☐ No

- **Cancer**

- Do you or have you had cancer?*

- ☐ Yes

- ☒ No

- Has anyone in your family ever been diagnosed with cancer?

- ☐ Yes

- ☒ No

- How are they related to you?

▼

- **Skincare Products**

- Are you using (or used):*

Select all that apply, or choose "None."

- ☐ None

- ☐ Azelex

- ☐ Differin

- ☐ Renova

- ☒ Retin-A

- ☐ Tazarac

- ☐ Accutane

- ☐ Glycolic or Alphahydroxy Acids

- How long?

6 months

- What are you using it for?

eye w rinkles and mouth w rinkles

- Have you noticed a difference?

- ☒ Yes
- ☐ No

- What difference have you noticed?

smoother

- Do you have any concerns with the use of this product?

- ☒ Yes
- ☐ No

-

-
- Do you have acne or experience frequent blemishes?

- ☒ Yes
- ☐ No

- **Allergies**

- Do you have any allergies?

- ☒ Yes
- ☐ No

- Please list allergies:

iodine

benedryl

w itch hazel

ragw eed

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- Are you taking [allergy](#) medications?
- ☒ Yes
- ☐ No

- List [allergy](#) medications:

cetirizine. flonase

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-
- Are you taking any medications not listed above?*
- ☒ Yes
- ☐ No

- Please list:

seroquel

w ellbutrin

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- What products do you presently use for face & body?*
- Please select all that apply.
- ☐ Soap

- ☐ ☒ Cleanser

☐ ☐ Toner

☐ ☐ Scrub

☐ ☒ Moisturizer

☐ ☒ Mask

☐ ☐ Sunscreen

☐ ☐ Other
- What brand/line are these products?

- How do these products seem to be working for you?
 - ☒ Very effective
 - ☒ Somewhat effective
 - ☐ Not effective
- How often do you use these products?

- What is the SPF in any [sunscreens](#) you may be using?

- Do you take any of the following?
 - ☐ None
 - ☒ Fish Oil
 - ☒ Flax Seed

- ☐ Multivitamin
- ☐ Energy-Enhancing Supplement

- What kind and how often?

daily

- Have you noticed a difference in anything?

- ☐ Yes
- ☒ No

- Daily water consumption?

1-4 glasses

- Daily caffeine consumption?

- ☐ None
- ☒ 1-2 cups of coffee
- ☐ 1-2 cans of soda
- ☐ ...or more

- How often do you exercise?

Weekends only

- Please check*

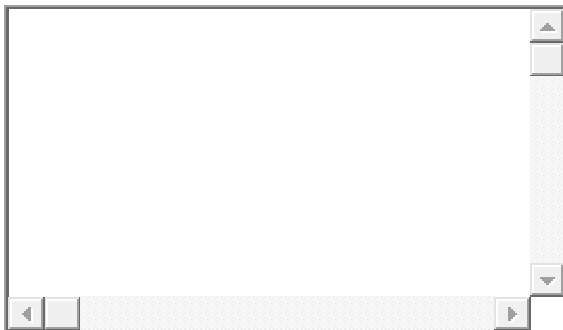
if you are affected by or are currently experiencing any of the following:

- ☐ None
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back problems
- ☐ Bleeding gums
- ☐ Blood disorders
- ☐ Broken Bones

- ☐ Bruise Easily
- ☐ Cardiac problems
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☒ Claustrophobia
- ☒ Cortisone treatments
- ☐ Diabetes
- ☐ DVT or Phlebitis
- ☐ Eating Disorder
- ☐ Eczema
- ☐ Epilepsy
- ☒ Fever blisters
- ☒ Headaches
- ☐ Hemophilia
- ☐ [Hepatitis](#)
- ☐ Herpes
- ☐ [HIV/AIDS](#)
- ☒ High blood pressure
- ☐ Immune Disorders
- ☐ Jaw [pain](#)
- ☐ Kidney [disease](#)
- ☐ Liver [disease](#)
- ☐ Lupus
- ☐ Metal pins or plates
- ☐ Nervous problems

- ☐ Numbness
- ☐ Pacemaker
- ☐ Psychological problems
- ☐ Radiation treatments
- ☐ Respiratory [disease](#)
- ☐ Shortness of breath
- ☒ Sinus problems
- ☐ Skin diseases
- ☐ Skin rash
- ☐ Swelling of feet or ankles
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Ulcer
- ☐ Urinary/kidney problems
- ☐ [Varicose Veins](#)
- ☐ Other

- Please explain any of the above,
including treatments or any significant others not mentioned:



- Please check any known allergies:
- ☐ Aspirin

- ☐ Barbiturates
- ☐ Codeine
- ☐ Iodine
- ☐ Local anesthesia
- ☐ Penicillin
- ☐ Sulfur
- ☐ Other

Submit