**Patient Questionnaire**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: ­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Gender: M F

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Telephone: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did you hear about us?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, whom should we contact? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Have you ever had (please check all that apply):

**□** Heart disease **□** Diabetes **□** Eye conditions

**□** Heart attack or chest pain **□** Easy bleeding or bruising **□** HIV or AIDS

**□** Hypertension **□** Delayed or abnormal wound healing **□** Endocrine or hormone disorder

**□** Heart pacemaker or defibrillator **□** Hepatitis **□**Currently pregnant or nursing

List any active medical problems you have: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications you currently take: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medication allergies you have: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any metals?:\_\_\_\_\_\_\_\_ Are you allergic to latex? \_\_\_\_\_\_\_\_ Do you use any tobacco products?: \_\_\_\_\_\_\_\_

**Surgical History**

List any operations you have had:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dermatologic History**

Have you ever had (please check all that apply):

**□** Chronic skin conditions **□** Skin cancer **□** Laser skin resurfacing

**□** Photosensitivity **□** Herpes simplex or cold sores **□** Chemical peel

**□** Keloid or hypertrophic scar **□** Accutane use for acne **□** Botox® injection

**□** Pigmentation disorder **□** Tetracycline use for acne **□** Injection of collagen or other dermal filler

**□** Recent waxing or plucking **□** Electrolysis or threading **□** Recent sunburn or tan (include tanning bed)

What is your ethnic background?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When exposed to the sun, do you usually: **□**Always burn, never tan **□**Burn easily, tan poorly **□**Tan after initial burn

**□**Burn minimally, tan easily **□**Rarely burn, tan darkly easily **□**Never burn, always tan darkly

Do you use sunscreen regularly?: \_\_\_\_\_\_\_\_\_\_\_\_\_ Do you use artificial or “sunless” tanning products?: \_\_\_\_\_\_\_\_\_\_\_

List any special skin care products you use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian (if Patient is under 18 years of age): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Updated 1/14/13