General Health History Form

First Name:_______________________Middle Initial:_____Last Name:_________________________
Address:____
City:____State:________Zip:________________________
Home Telephone:_____________________________Mobile:________________________________
Date of Birth:_________________Age:_______Hereditary backround?_________________________
Email Address:_____________________________________@__________________________________

How would you describe your skin? ____Oily____Sensitive____Dry____Normal____Combination

Have you received any of the following procedures?

____Chemical Peel
____Microdermabrasion
____Dermaplaning
____Facial Ultrasound
____Facial
____Laser Hair removal
____Eyelash/Eyebrow Tint
____Waxing
____Skin Care Products

Other:____

If yes, please explain:
____
____

Have you used any of the following topical/oral medications?

____Accutane
____Renova
____Hydroquinone
____Differin
____Tazorac
____Ziana
____Retin-A
____Trentinoin
____Alpha Hydroxy Acids
____Avage
____EpiDuo
____Topical Antibiotics

Other:____

Current Medications:
(Include Birth Control, Herbal Supplements, Vitamins, and over the counter)

1.____
2.____
3.____
4.____
5.____
6.____________________________________
7.____________________________________
8.____________________________________
9.____________________________________
10.___________________________________

Habits:	Never	Frequency Of Use	# Of Years	Date Last Used
Tobacco		Packs/day		
Alcohol		Beverages/day		
Caffeine		Glasses/day		
Drugs Used:				

Allergies (Food, Latex or Medications) ____Yes ____No **if yes, please list:**

____

Medical History

Have you ever had any of the following conditions?

Condition	Yes	No
Acne	____Yes	____No
Arthritis	____Yes	____No
Diabetes	____Yes	____No
Severe Headache/Migraine	____Yes	____No
Cold Sores/Fever Blisters	____Yes	____No
Seizures	____Yes	____No
Cancer	____Yes	____No
Heart Conditions	____Yes	____No
Pacemaker/Metal Implants	____Yes	____No
Hepatitis	____Yes	____No
Skin Disorder	____Yes	____No
Hypertrophic scaring	____Yes	____No
Bleeding Disorder	____Yes	____No
HIV/AIDS	____Yes	____No
Thyroid Disease	____Yes	____No
Lupus	____Yes	____No

Review of Systems

How much water do you consume daily?____

Question	Yes	No
Do you currently have a sunburn/windburn or red face?	____Yes	____No
Are you in the habit of using tanning booths?	____Yes	____No
Are you pregnant or breast feeding?	____Yes	____No
Do you wear contact lenses or glasses?	____Yes	____No
Do you have intolerance to heat or cold?	____Yes	____No
Do you have any other medical conditions?	____Yes	____No

If yes, please explain:

____

Do you understand that every procedure/operation is followed by a period of healing before the tissue returns to normal and the final result is apparent? ____Yes ____No

Do you understand that the objective of any cosmetic procedure is an improvement and not perfection? ____Yes ____No

____ ______________________

Patient Signature Date

____ ______________________

Parent/Guardian Signature (If under the age of 18) Date

____ ______________________

Health Care Provider Signature Date