

Fresh Skin Care & Aesthetics
Medical History

Name: _____ Date: _____

(PLEASE PRINT CLEARLY)

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Sex: M F Marital Status: S M D Email: _____

Birthdate: _____

Employer: _____ Work Phone: _____

Primary Physician: _____ Dermatologist: _____

How were you referred: newspaper, radio, doctor, friend, internet, other

If friend, please include name of friend: _____

Reason for visit: _____

Do you have any allergies(food or plant)? Y N _____

If yes, please list: _____

Are you presently under a physician's care for any current skin condition or other problem? Y N If yes, what? _____

Are you pregnant? (Women only) Y N Have you had skin cancer? Y N

Are you now using (or have used): Azelex, Differin, Renova, Retin-A, Tazarac, Glycolic, or Alpha Hydroxyl Acids

Are you presently taking medications-oral or topical: _____

Do you have any permanent makeup or tattoos in the area to be treated? Y N

Do you have any medical implants such as pacemaker, defibrillator, etc.? Y N

Have you had unprotected sun exposure or used tanning creams in the last 4 weeks? Y N

Please circle if you are affected by or have any of the following:

Asthma
Cardiac Problems
Depression/Anxiety
Diabetes
Eczema
Epilepsy
Fainting Spells
Fever Blisters
Headaches
Heart Disease
Hepatitis
Herpes
High Blood Pressure
Hysterectomy
Immune Disorders
Irregular Heartbeat
Keloid Scars
Lupus
Metal bone/
pins/plates
Pacemaker
Polycystic Ovary Disease
Rosacea

Seizure Disorder
Sinus Problems
Skin Diseases
Stroke
Thyroid Disease
Urinary or Kidney Problems