THE VITALITY CENTER
Individual and Family Care

MEDICAL HISTORY FOR SKIN PROCEDURES

Name: _____

Address: _____

Primary Phone: _____

Email: _____ **Referred by:** _____

☐ **Please check here if you want to receive updates and promotions**

☐ **Please check here if you would like auto-reminders for your appointments**

Female ☐ **Male** ☐ **DOB:** ___/___/___

Reason for consultation

☐ Acne

☐ Brown spots or sun damage

☐ Enlarged blood vessels

☐ Fine lines or wrinkles

☐ Cellulite

☐ Elasticity

☐ Dryness

☐ Scarring

Questions about skin

1. How long have you been concerned about this area(s)? _____

2. At what age did you notice this concern(s)? _____

3. Are your present skin concern(s) getting more pronounced? ☐ Yes ☐ No

4. Have you ever been treated for this concern(s)? ☐ Yes ☐ No

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5. Are you currently taking medication for your skin's concern(s)? ☐ Yes ☐ No

6. What topical skin medications or products are you currently taking?

☐ Retin-A® ☐ Hydroquinone or bleaching agent ☐ Other

7. Have you ever had laser/IPL hair removal? ☐ Yes ☐ No

8. Have you ever used the following hair removal methods in the past 6 weeks?

☐ shaving ☐ waxing ☐ electrolysis ☐ plucking/tweezing ☐ stringing ☐ depilatories

9. Have you ever had skin resurfacing or rejuvenation or chemical peels? ☐ Yes ☐ No

10. Have you ever had treatments for pigmented lesions? ☐ Yes ☐ No

11. Do you form thick or raised scars (keloids) from cut or burns? ☐ Yes ☐ No

12. Do you experience hyperpigmentation (redness) from burns, cuts, insect bites? ☐ Yes ☐ No

13. Have you had cold sores or fever blisters? ☐ Yes ☐ No

Skin Type choices (when exposed to sun for about 1 hour with no protection):

- Always burns, never tans ☐
- Always burns, sometimes tans ☐
- Sometimes burns, always tans ☐
- Rarely, burns, always tans ☐
- Brown, moderately pigmented skin ☐
- Black skin ☐

When were you last exposed to the sun or tanning booth?_____

1. Do you use self tanners? ☐ Yes ☐ No

2. Are you planning a vacation in the sun? ☐ Yes ☐ No

Personal history:

1. Do you smoke? ☐ Yes ☐ No if yes___packs per day

2. What is your daily consumption of alcohol? _____

3. Do you wear contact lenses? ☐ Yes ☐ No

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Medical history:

1. Are you currently under the care of a physician? ☐ Yes ☐ No. If yes, for what:

2. Do you have any of the following?

☐ Arthritis	☐ Bleeding disorders	☐ Dark spots of pregnancy
☐ Any active infection	☐ Bruising	☐ Diabetes
☐ Epilepsy	☐ HIV/Aids	
☐ Heart Disease	☐ Sensitive teeth	
☐ Hepatitis	☐ Skin cancer or moles	
☐ Herpes Simplex	☐ Skin injury	
☐ High blood pressure	☐ Vision deficits	
☐ Hormone imbalance	☐ Other	

3. Do you have allergies to any of the following? (check all that apply) ☐ medications ☐ latex

☐ food ☐ plants ☐ anesthesia ☐ other_____

4. Do you take any of the following?

☐ Accutane	☐ Appetite Depressants	☐ Insulin
☐ Antibiotics	☐ Aspirin or Ibuprofen	☐ Sedatives
☐ Anti-coagulants	☐ Cortisone or steroids	☐ Thyroid medication
☐ Anti-depressants	☐ Hormone/contraceptives	☐ Other_____

5. Do you take any supplements or herbal remedies? ☐ Yes ☐ No

Please list: _____

For female patients:

1. Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

Do you have a medical device or implant, if so list: _____

I have answered the questions contained in this questionnaire to the best of my knowledge. I understand that it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this information as it occurs.

Signature:_____ **Date:**_____