Sheer Beauty
MEDICAL SKIN CARE

Original Date:
Intake ID: (OFFICE ONLY)

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(First,Last):* ☐ M ☐ F	**Age:**
Concerns:	**Occupation:**
Are you taking Accutane? **Retin-A?Retinol?** **Hydraquinone?**	**Date of last Aesthetic Treatment:**

PERSONAL HEALTH HISTORY		
List any medical problems that other doctors have diagnosed		
Surgeries		
Year	Procedure/Reason	Hospital
FAMILY HEALTH HISTORY		
Member	Procedure/Reason	Hospital
Father		
Mother		
Other		

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers, Skin care products,etc.		
Name the Prescription	Strength	Frequency Taken
Allergies to Medications, Fabrics, Herbs, Food, Etc?		
Allergy:	Reaction You Had:	

HEALTH HABITS AND PERSONAL SAFETY			
For women	Are you trying for a pregnancy?	☐ Yes	☐ No
	Are you taking any contraceptives (birth control)?	☐ Yes	☐ No
	Are you taking any Hormone replacements?	☐ Yes	☐ No
	Are you Pregnant or lactating?	☐ Yes	☐ No

SKIN HEALTH

Have you ever seen a Dermatologist or other Doctor for you skin?	☐ Yes	☐ No
Are you under treatment for any current skin condition?	☐ Yes	☐ No
Which conditions would you like to improve: (Check all that apply) o Acne Scarring o Acne o Age Spots o Broken Capillaries o Enlarged Pores o Fine Lines/Wrinkles o Hyperpigmentation o Stretch Marks o Surgical/facial scars o Other_____	☐ Yes	☐ No
Have you ever had: (Check all that apply) o Peels o Microdermabrasion o Facial Surgery o Cosmetic Surgery o Botox o Collagen Injections o Hyaluronic Acid-Fillers o Laser Resurfacing o Any Other Corrective Treatments? o If YES, Please Explain:_____	☐ Yes	☐ No
Do you now have or have you ever had? (Check all that apply) o Keloids/Abnormal or raised scarring o Large areas of skin discoloration problems o Eczema o Psoriasis o Abnormal moles o Skin Cancer-Melanoma o Skin Cancer-Squamous Cell o If YES, Please Explain:_____	☐ Yes	☐ No
How would you rate your skin? (circle one) I. Always Burns, never tans II. Burns easily, tans slightly III. Burns moderately-Tans gradually IV. Seldom burns-Deep tan V. Rarely Burns-Deep tan VI. Never burns-Deeply pigmented Do you ever experience: (Circle one) Flakiness Tightness Redness Excessive oily shines during the day		
What is your present skin care regimen? (Check all that apply) o Cleanser o Toner o Exfoliation o Serums o Creams o Sun-Block o Make-up	☐ Yes	☐ No
Are you ever exposed to chemicals, oils or caustic substances that may aggravate you skin? **If yes, what are they?**_____	☐ Yes	☐ No
Do you: Sun Bathe or Use a tanning bed **If Yes, How often?**_____	☐ Yes	☐ No
In our treatment program, it may be necessary to recommend alterations to or additions in your home care regimen; would that be OK with you?	☐ Yes	☐ No