# Medical Health History & Skin Questionnaire

Name: ________________________________________ Gender: M F Birth date: __________ Age: ____
Address: ____________________________________________ Height: _________ Weight: __________
City: ________________________________________________________
State/Zip:________________________
Email Address: ______________________________________ Cell Phone: _______________________
Occupation: __________________________________________ Home Phone: _____________________
Emergency Contact: ____________________________________ Phone: _________________________
Pharmacy: _____________________________________ Pharmacy Phone: ________________________
How Did You Hear About Us? __________________________________________________________

**MEDICAL HISTORY**

1. Have you been or are you currently under the care of a physician or other medical professional within the past year?
Yes No
If yes, list doctor's name(s)/number(s): _____________________________________________________

2. Have you seen a dermatologist in the past year? Yes No
If yes, list dermatologist's name, contact info, and reason for visit: ______________________________
______________________________________________________________________________________

3. Please list any previous hospitalizations/operations: ________________________________________
______________________________________________________________________________________

4. Are you currently taking any medications or antibiotics? Yes No
If yes, please list: _________________________________________________________________________
______________________________________________________________________________________

5. Do you take nutritional supplements? Yes No If yes, what? ______________________________
6. Are you using topical medications? Yes No If yes, what? ______________________________

7. How is your general health? Excellent Good Fair Poor

8. Do you exercise? Yes No 9. Do you smoke? Yes No 10. Do you drink alcohol? Yes No

11. Have you ever had Herpes Simplex Virus? Yes No
If yes, have you ever been treated with Denavir (Penciclovir), Zovirax (Acyclivor) or Abreva? Yes No

12. Are you being treated for Hepatitis? Yes No

13. Please circle if you are presently experiencing or have experienced any of the following:

| Skin Cancer | Dermatitis | Keloid Scarring | Rosacea | Acne |
|---|---|---|---|---|
| Broken Capillaries | Treatment Reactions | Hypopigmentation | Hyperpigmentation | |

14. Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? Yes No If yes, please describe: _________________________________

**Female Clients Only:**
Are you on hormone replacement therapy? Yes No
Are you presently taking birth control pills? Yes No
Are you pregnant, trying to get pregnant, or nursing? Yes No
**Do you have any allergies?** Yes No If yes, what? ____________________________________
**Have you ever had an anaphylactic reaction? Yes No**
**Have you ever had an allergic reaction to any of the following?**

| | | | | | |
|---|---|---|---|---|---|
| AHA's | Yes | No | Aspirin or Salicylates | Yes | No |
| Alcohol based products | Yes | No | Aloe Vera | Yes | No |

| | | | | | |
|---|---|---|---|---|---|
| Animals | Yes | No | Apples | Yes | No |
| Benzoyl Peroxide | Yes | No | Blood Transfusions | Yes | No |
| Citrus | Yes | No | Cosmetics | Yes | No |
| Drugs | Yes | No | Eggs | Yes | No |
| Fish, Marine or Iodine | Yes | No | Food | Yes | No |
| Grapes | Yes | No | Human Albumin | Yes | No |
| Hydroquinone | Yes | No | Ingredients in Skincare Products | Yes | No |
| Latex | Yes | No | Milk | Yes | No |
| Perfumes/Fragrances | Yes | No | Pollen | Yes | No |
| Sunscreens | Yes | No | | | |

**Had neurotoxin injections before?** _____ Last Treatment _____ What Areas ________________________
Where you happy with your previous neurotoxin treatments? ______ Explain _________________________
Did you have any adverse outcomes? What were they?__________________________________________
Have you ever had an eyelid/eyebrow droop after neurotoxin? _____________________________________
Areas of special concern to patient? __________________________________________________________
**Had Juvederm/Restylane injections before?** _____ Last Treatment _____ What Areas _____________
Where you happy with your previous filler treatments? ______ Explain ___________________________
Did you have any adverse outcomes? What were they?__________________________________________
Areas of special concern to patient? __________________________________________________________

**Please circle if you have had any of the following in the last 14 days:**
Facial Cosmetic Surgery If yes, explain: _____________________________________________________
Botox Injections If yes, explain: _____________________________________________________________
Fillers If yes, explain: ____________________________________________________________________
Light Treatments If yes, explain: _____________________________________________________________
Laser Treatments If yes, explain: _____________________________________________________________
Microdermabrasion If yes, explain: ___________________________________________________________
Other If yes, explain: _____________________________________________________________________

**Please circle the following conditions you have or have experienced:** **OR: None _______**

Amyotrophic Lateral Sclerosis (ALS) anemia artificial implants arthritis
autoimmune disorder asthma blood thinner blood disorder - bleeding
blood disorder – clotting burn/skin graft cardiac problems conjunctivitis
cancer claustrophobia cold sores contact lenses constipation
diabetes eczema epilepsy eating disorder high cholesterol
eye disease fainting/dizziness hepatitis heart attack Hirsutism
hernia hormone imbalance HIV headaches high/low blood pressure
hypertension irregular pulse insomnia Kidney disease Lambert-Eaton Syndrome
lupus liposuction metal plate Multiple Sclerosis muscle weakness
nail disorders neurological disorder numbness Myesthenia Gravis Parkinson's Disease
pacemaker PCOS/ovarian cysts phlebitis psychiatric disorder psoriasis
seborrhea seizures skin disorder spina bifida spinal injury scarring issue/keloid
tooth fillings thyroid disorder stroke varicose vein Vitiligo vision problems

## SKINCARE HISTORY

1. Please circle any of the following prescription products that you have used or are currently using:

Tretinoin (Retin A, Retin-A Micro, Renova, Avita) Adepalene (Differin) Triluma
Azelaic Acid (Azelex, Finacea) Tazarotene (Tazorac) Metrogel

If yes, what strength? _______________ ____ For how long? __________________________________
How frequently? ________________________ Where applied? ___________________________________
2. Have you ever taken Accutane? Yes No If yes, when did you stop? ________________________
3. Any other topical antibiotics? Yes No If yes, please list: __________________________________

4. Please circle if you are presently using or have used any of the following in the past:

Benzoyl Peroxide (BP) | Glycolic Acid (AHA) | Lactic Acid (AHA)
Resorcinol | Salicylic Acid (BHA) | Any Vitamin A products

5. What skincare products are you currently using at home?

Cleanser ________________________________________ Vitamin C __________________________________
Toner ________________________________________ Exfoliant/Scrub ______________________________
Moisturizer ____________________________________ Mask ______________________________________
Specialty Products _______________________________ SPF ______________________________________

6. Do you currently have windburn/sunburned/red face? Yes No If yes, explain: ________________

7. Please circle if you are currently receiving any of the following: facial waxing, electrolysis, laser hair reduction treatments, or use depilatories? Yes No

8. Have you ever had a microdermabrasion treatment? Yes No How long ago? __________________

9. Have you ever had a chemical peel? Yes No Within the last 14 days? Yes No
What kind? ____________________ Describe your reaction: ______________________________________

10. Have you ever had a facial treatment or spa body treatment before? Yes No
If yes, what kind? ____________________________________________________________________________

11. Are you currently having skin treatments? Yes No
If yes, what type of treatment(s)? __________________________________________________________

12. Do you use a sunscreen? Yes No
If yes, what level of protection? _________

13. Do you sunbathe or participate in outdoor activities? Yes No

14. Do you tan in a tanning booth? Yes No
Have you tanned in a booth in the last 14 days? Yes No

15. Have you had any direct sun exposure in the last 10 days? Yes No

16. What is your ethnic background? ________________________________________________________

17. When exposed to sun do you: Always burn, never tan | Always burn, sometimes tan | Sometimes burn, sometimes tan | Always tan

18. Do you feel your skin is sensitive? Yes No

# Fitzpatrick Skin Test

**Skin Type Evaluation** **Name:** ____________________

SKIN TYPE

| | 0 | 1 | 2 | 3 | 4 | YOUR SCORE |
|---|---|---|---|---|---|---|
| Your natural eye color? | Light: Blue, Gray or Green | Med: Blue, Gray or Green | Blue | Dark Brown | Brownish Black | |
| Natural color of your hair | Sandy or Red | Blonde | Chestnut or Dark Blonde | Dark Brown | Black | |
| Color of your non-exposed skin? | Reddish | Very Pale | Pale with Beige Tint | Light Brown | Dark Brown | |
| Do you have freckles on non-exposed areas? | Many | Several | Few | Incidental | None | |

TOTAL **GENETIC DISPOSITION** SCORE: ________

REACTION

| | 0 | 1 | 2 | 3 | 4 | YOUR SCORE |
|---|---|---|---|---|---|---|
| What happens if you stay too long in the sun? | Painful redness, blistering, peeling | Blistering, followed by peeling | Burns, sometimes followed by peeling | Skin rarely burns | Skin never burns | |
| To what degree do you turn brown? | Hardly or not at all | Light tan color | Reasonable tan | Tan very easily | Turn dark brown quickly | |
| Do you turn brown within several hours after sun exposure? | Never | Seldom | Sometimes | Often | Always | |
| How does your face react to the sun? | Very sensitive | Sensitive | Normal | Very resistant | Never had a problem | |

TOTAL **SUN REACTION** SCORE: ________

TANNING

| | 0 | 1 | 2 | 3 | 4 | YOUR SCORE |
|---|---|---|---|---|---|---|
| When did you last expose the area to be treated to sun, tanning booth, cream or spray tan? | More than 3 months ago | 2-3 months ago | 1-2 months ago | Less than 1 month ago | Less than 2 weeks ago | |
| Did you expose the area to be treated to the sun? | Never | Hardly ever | Sometimes | Often | Always | |

TOTAL **TANNING HABITS** SCORE: ________

TOTAL SCORE: ________

| TOTAL SCORE | FITZPATRICK SKIN TYPE | RESPONSE TO UVA | SKIN COLOR |
|---|---|---|---|
| 0-7 | I | Never tans, always burns | Ivory White |
| 8-16 | II | Tans with difficulty | Fair or Pale |
| 17-24 | III | Average tanning, sometimes burns | Fair to Beige, with golden undertone |
| 25-30 | IV | Easily tans, rarely burns | Olive or Light Brown |
| Over 30 | V | Very easy to tan, very rarely burns | Dark Brown |
| Over 30 | VI | Easily tans, rarely burns | Black |

*These questions have been answered accurately and to the best of my knowledge.*

**Name:** ____________________ **Date** ________

| **I would like to know more about: (Please circle all that apply)** | | |
|---|---|---|
| BOTOX Cosmetic/Dysport for wrinkles | Drooping brow | Birthmark |
| Dermal Fillers (Juvederm, Restylane) | Drooping eyelids | Facial veins |
| Volume loss in cheeks | Crow's feet | Facial Redness |
| Facial fullness/drooping/sagging | Thin lips | Unwanted hair |
| Facial Contouring | Frown Lines | Skincare products/advice |
| Nose size or shape | Laser Skin Resurfacing | Eyelash length/fullness/color |
| Submental fullness (double chin) | Brown spots/age spots/freckles | |

**What areas of concern do you have regarding your: (Please circle any that apply)**

**SKIN**

| | | |
|---|---|---|
| Acne and/or breakouts | Blackheads/whiteheads | Broken capillaries/redness |
| Dehydrated | Dull/dry skin | Enlarged pores |
| Excessive Oil/Shine | Facial scarring | Fine lines and wrinkles |
| Flaky skin | Hyperpigmentation (freckles/spots) | Hypopigmentation |
| Rosacea | Sun spot/liver spot/brown spot | Sun damage |
| Uneven skin tone | Other: ______________________________ | |

**EYES**

Dehydrated    Wrinkles    Puffiness    Dark Circles    Other

**LIPS**

Dehydrated    Cracked/chapped    Other: ___________________

Is there any other necessary information RENEW's Nurse/Esthetician should know before beginning your treatment?
Yes    No

If yes, please explain: ___________________________________________________________
___________________________________________________________________________

***I acknowledged that all the information provided by me in this Medical Health History & Skin Questionnaire is true and correct to the best of my knowledge. I understand that skin conditions may require more than one treatment and home care products to achieve the result s desired. Results cannot be guaranteed due to individual skin types and conditions. I understand I need to sign this waiver and complete ANY changes prior to every treatment that I receive at RENEW.***

X________________________________________________ **Date:** ___________________
**Client Signature**

X_________________________________________________________________________
**Printed Name**

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