

Personal Image Center Health Questionnaire

Name _____ Age _____

List all current medical problems _____

List all current daily medications (include vitamins, herbs, over the counter meds)

List any allergies _____

Patient History

Have you every taken accutane? Dates _____ Dosage _____ Months _____

Have you used tretinoin/retin-A? Dates _____ Percentage _____

Do you use birth control pills? _____

Are you pregnant? _____

Are you breast-feeding? _____

Are you attempting pregnancy? _____

Do you have herpes simplex/cold sores? _____

Do you form keloids/or hypertrophic scars? _____

Any skin disorders (please specify) _____

Any history of cancer(please specify) _____

Do you regularly take aspirin/motrin or steroids? _____

Any major weight loss or gain and how much? _____

Do you have a history of anemia or bleeding tendency? _____

Any high blood pressure? _____

Any other health issues? (please specify) _____

Previous Procedures (Please give dates)

Botox (specify sites) _____

Fillers (specify names and sites) _____

Cosmetic surgery (specify) _____

Facials (type and how many in last 12 months) _____

Peels (Specify type light,medium,deep,other) _____

Lasers (hair removal, IPL(photofacial), skin tightening, ablative,nonablative, peels,veins)

Other Treatments _____

Please specify any negative reactions to previous procedures _____

Current skin care products used _____

I certify that I have disclosed my medical history to the best of my knowledge

Patient Signature _____

Date _____

Physician Signature _____

Date _____