SpectacularSkin

# SpectacularSkin, Inc. Health Questionnaire

Name: Date:

Age: DOB:

Email: Gender:

Address: Cell:

Emergency contact:

Who referred you to us?

What is your daily skin care regimen?

| Which of the following describes your skin type? | |
|---|---|
| ____Very oily, large pores | ____Oily skin |
| ____ Sensitive skin | ____ Combo skin oily t/dry cheeks |

| Medication History (Mark if current or past and provide details below): | | |
|---|---|---|
| ___ Accutane | ___ Retin-a/Tretinoin | ___ Hydroquione or bleaching agent |
| ___ Antibiotics | ___ Anti-depressants | ___ Vitamins /Supplements |
| ___ Insulin | ___ Aspirin/ibuprofen | ___ Appetite suppressants |
| ___ Sedatives | ___ Blood thinners | ___ Hormones/contraceptives |
| ___ Thyroid med. | ___ Cortisone or steroids | ___ Other (List below) |
| If yes provide details (Name/Dosage/ last dose?): | | |

| Skin History: | | |
|---|---|---|
| ___ Unwanted hair | ___ Spider veins | ___ Acne/Acne scarring |
| ___ Dry Skin | ___ Melasma | ___ Pigmented lesions |
| ___ Large pores | ___ Rosacea | ___ Brown Spots/ Sun Damage |
| ___ Fine lines and wrinkles | | |
| How long have you had these concerns? | | |
| Do you feel like your condition is worsening? | | |
| Have you ever been treated for this? | | |
| If yes, please explain: | | |

| Medical diagnoses: | | |
|---|---|---|
| ___ Arthritis | ___ Active infection? Expl. | |
| ___ Bleeding disorder | ___ Bruising | ___ Cancer |
| ___ Epilepsy/seizures | ___ Hepatitis | ___ Skin Cancer/Moles |
| ___ High Blood Pressure | ___ Herpes simplex | ___ Diabetes |
| ___ High cholesterol | ___ Hormone Imbalance | ___ Skin Injury |
| ___ Heart issues | ___ Respiratory issues | ___ Kidney issues |
| ___ Liver issues | ___ Hashimotos | ___ Graves disease |
| ___ Marfans syndrome | ___ Sclederma | ___ Genetic disorder |
| ___ Polysystic Ovarian Syndrome | ___ Allergies | ___ Other |
| Explain: | | |

| Sun History: | |
|---|---|
| Age at first sunburn? | Date of last sunburn? |
| Are you frequently outside? | When were you last in direct sun? |
| Do you use tanning beds? | Last time used tanning bed? |

| Questionnaire: | | |
|---|---|---|
| Do you get cold sores or fever blisters? | ___ Yes | ___ No |
| Do you form thick raised scars? | ___ Yes | ___ No |
| Do you develop Hyperpigmentation? | ___ Yes | ___ No |
| Do you use self tanners? | ___ Yes | ___ No |
| Will you be vacationing in sun in next 3mo? | ___ Yes | ___ No |
| Have you ever had a stroke, Bell's palsy, nerve injury? | ___ Yes | ___ No |
| Do you need to take antibiotics before dental procedures? | ___ Yes | ___ No |
| Do you have a pacemaker or other implantable device? | ___ Yes | ___ No |
| Are you on BHRT? | ___ Yes | ___ No |
| Are you a physician? | ___ Yes | ___ No |
| Female Only Below | | |
| When was your last period? | | |
| Are they regular? | ___ Yes | ___ No |
| Are you pregnant? | ___ Yes | ___ No |
| Are you trying to become pregnant? | ___ Yes | ___ No |
| Breastfeeding? | ___ Yes | ___ No |
| Are you Post menopausal? | ___ Yes | ___ No |

| Do you have allergies to any of the following? | | |
|---|---|---|
| ___ Topical skin care products | ___ Anesthesia | ___ Medications |
| ___ Latex | ___ Dust | ___ Plants |
| ___ Food | | |
| If so, please explain: | | |

I have answered the questions contained in this health questionnaire form to the best of my knowledge. I understand it is my responsibility to inform SpectacularSkin, Inc. of my current health conditions while seeking treatment as a patient. I will update this information as it occurs if there are changes to my health in between treatments.

Signature: Date: