REFLECTIONS medspa AT DERMATOLOGY ASSOCIATES

HISTORY AND SKIN HEALTH QUESTIONNAIRE

CLIENT INFORMATION

Name _____ E-Mail Address _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Other _____

MEDICAL INFORMATION

Date of Birth _____ Age _____

Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No Issues with healing/scarring? ☐ Yes ☐ No

Have you ever been treated for:

☐ Acne ☐ Depression ☐ Skin Disease ☐ High Blood Pressure ☐ Cold Sores ☐ Diabetes ☐ Cancer ☐ Auto-Immune Disease

☐ Photosensitivity ☐ Hepatitis B/C ☐ HIV ☐ Neurological Disorders ☐ Allergies (including topical and latex) _____

_____

List all medications you are currently taking _____

Are you Pregnant? ☐ Yes ☐ No Trying to get Pregnant? ☐ Yes ☐ No Are you on Hormone Therapy/Birth Control? ☐ Yes ☐ No

Do you wear Contact Lenses? ☐ Yes ☐ No Any eye disorders? ☐ Yes ☐ No

PERSONAL INFORMATION

Do you exercise? ☐ Yes ☐ No How Often? _____ Do you use tanning beds? ☐ Yes ☐ No

When was your last sunburn? _____

Have you had cosmetic procedures? ☐ Yes ☐ No ☐ Laser ☐ Chemical peels ☐ Permanent Make-up

☐ Botox ☐ Filler ☐ Other _____

Have you ever been under the treatment plan of a: ☐ Dermatologist ☐ Plastic Surgeon ☐ Aesthetician

What skin care line are you currently using? _____

Cleanser _____ Moisturizer _____ Sunscreen _____

Eye Cream _____ Mask _____ Night Repair Cream _____

Are you using, or have you used? ☐ Alpha/Beta Hydroxy Acids ☐ Retin-A ☐ Accutane (within the past year)

Do you take, or have you taken Bisphosphonate/Diphosphonate? ☐ Yes ☐ No

Your skin type is? (Please choose ONLY one.) ☐ Normal ☐ Dry/ Dehydrated ☐ Oily ☐ Acne/Acne Prone

Please check all treatments/services that interest you:

☐ SculpSure ☐ Botox ☐ Juvederm/fillers ☐ PRP ☐ IPL ☐ Kybella ☐ Hair Removal ☐ Laser Resurfacing ☐ HydraFacial/facials

☐ Dermaplaning ☐ Micro-needling ☐ Microblading ☐ Chemical Peels ☐ Professional Skin Care Program

☐ Other/comments: _____

I certify that the information given is true to the best of my knowledge and certify that I will notify the office immediately if any changes occur in my medical history/health status. I am also aware of the $25 no-show fee if I do not notify the office within 24 hours of my appointment. All Groupon treatments must be completed within one year of purchase.

Patient Signature _____ Date _____

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