MEDICAL/SKIN CARE QUESTIONNAIRE

Belladerm MedSpa

Patient Name (please print): _____ **Age:**_____ **Date of Birth:**_____

Address: _____

City: _____**State:**_____ **Zip Code**:_____

Home Number: (_____)_____ **Work Number**: (_____)_____

Cell Number: (_____)_____ **Email:** _____

Occupation:_____

Please list all medications which you are currently taking or have used in the past 6 months (be sure to include any of the following: birth control pills, aspirin or ibuprofen containing drugs, weight loss medications, Coumadin or any blood thinning medication, prescription eye drops, steroids) **Use back of page if necessary.**

Medication(s) Amount Frequency

Please list all Naturopathic or Health Food Supplements:

Emergency Contact_____Phone_____

List all **ALLERGIES** including **LATEX**: _____

Are you a smoker? YES/ NO Ex-smoker: YES/ NO

How much are (were) you smoking? _____ How long? _____ Quit how long ago? _____

How much alcohol do you drink?_____ Caffeine Use_____

Please circle all the following medical conditions you now have or have had in the past:

Thyroid Disease / Cancer / Bleeding Tendency / Diabetes / Blood Transfusions / Glaucoma / Lung Disease / TB / Asthma or Wheezing / Emphysema / Neurological Disorders / Irregular Heart Beat / Chest Pain / Heart Disease / High Blood Pressure / Heart Attack / Stroke / Epilepsy / Heart burn / Intestinal Ulcers or Bleeding / Rheumatoid Arthritis / Scleroderma / Lupus / MS / Myasthenia Gravis / Raynaud's Syndrome / Porphyria / Depression / Mental Illness / Drug or Alcohol Addiction / Hepatitis B / Hepatitis C / HIV / Any other serious illness or injury / None of the above

Use Back Page to Give Details of any Circled Items

Are you pregnant or lactating? YES / NO

When was your last menstrual period? _____

Do you experience vaginal laxity or dryness? _____

Do you experience stress incontinence? _____

Do you have a history of herpes simplex (cold sores)? _____ When was the last outbreak? _____

Do you have a history of developing keloids (raised scars)? YES/NO

Have you ever been diagnosed with Vitiligo (pigment loss in the skin)? YES/NO

Have you ever seen a dermatologist for your skin? YES/NO If so, for what?_____

What topical medications do you use, or have you used? _____

Do you use any form of Retin-A, Glycolic Acid or Salicylic Acid? YES/NO

Have you ever been on Accutane? YES/NO If so, how long ago? _____

Have you ever had Botox™ or Dermal Filler injections? YES/NO If so, how long ago?_____

Have you ever had a bad reaction to any skin care products? YES/NO

Have you ever had a chemical peel? YES/NO Did you have any adverse reactions? YES/NO

What skin care products are you currently using? _____

Do you use a sunscreen? YES/NO

Do you wax or use depilatories on your face? YES/ NO If so, when was the last time?_____

When did you last tan or use a tanning bed?_____

Do you have a history of atypical moles, melanoma or skin cancer in yourself or family? YES / NO

Does your skin ever flake or feel tight and dry? Frequently Occasionally Very Rarely

Does your skin get oily a few hours after cleansing? YES/NO

Do you have a history of acne or periodic outbreaks? YES / NO

What would you like to see changed about your skin? _____

List all surgeries that you have had (include plastic surgery)	Date:

Have you or anyone in your family ever had unusual reactions to topical anesthetics (numbing cream)? YES / NO

I acknowledge that I have disclosed my complete medical history and the above is a complete and accurate representation of my medical and psychological status.

Patient Signature: _____ Date: _____