SERIOUSLY SKIN

Patient Name: ______________________________ Date: ______________________________

DOB: ______________________ Age: ________ Circle one: **MALE** **FEMALE**

Address: ______________________________ City: ______________________________

State: ________ Zip: ______________ Occupation: ______________________________

Home Phone: (_____)______________________ Cell Phone: (_____)______________________

Work Phone: (_____)______________________

Email Address:____

I wish to be contacted in the following manner (Check all that applies).

☐ Home Telephone

(________) ______________________

☐ Work Phone

(________) ______________________

☐ Cell Phone

(________) ______________________

☐ **Leave message with call back number and appointment confirmation only.**

☐ **OK to leave a message with detailed information**

☐ OK to fax information as needed to this fax number

(________) ______________________

Additional family members if any, who we may contact:

Name: ______________________________ Name: ______________________________

(_______) ______________________________ (_______) ______________________________

EMERGENCY CONTACT

Name: ______________________________ Relationship: ______________________

Address: ______________________________ Phone: (_____) ______________________

HOW DID YOU HEAR ABOUR SERIOUSLY SKIN? Circle as many as apply

Doctor: ______________________ Friend: ______________________

Internet Groupon Living Social Chagrin Valley Times Currents Billboard

Other: ______________________________

PATIENT IS RESPONSIBLE FOR PROVIDING ANY NESSESARY CHANGES TO THIS FORM

SERIOUSLY SKIN

GENERAL MEDICAL HISTORY

Patient Name: ____________________ **Date:** ____________________

Area of Concern/Reason for Visit? ____________________

REASON FOR CONSULTATION? Please Circle: Acne Brown Spots/Sun Damage Enlarged Blood Vessels Fine Lines/Wrinkles Flushing of the Skin Skin Laxity Skin Texture/Scars Unwanted Hair Unwanted Tattoo

Other:____________________

How long have you been concerned about the area (s) ?____________________

At what age did you notice this concern? __________ Are you present skin concerns getting more pronounced? Yes No

Have you ever been treated for this concern? Yes No If yes, what is it? ____________________

What method of treatment? ____________________

Are your currently taking medication or using product (serums, cleaners, creams, etc.) for your skin concerns Yes No

If yes, what are you using? ____________________

Are you allergic to any medications? ***Yes No*** **If YES, please specify:** ____________________

Do you have any other allergies? ***Yes No*** **If YES, please specify:** ____________________

Current Medication: (Please include over the counter meds, vitamins, and herbals)____________________

____

Are you currently taking Antibiotics? ***Yes No***

Preferred Pharmacy Name and Location: ____________________

<u>PATIENT MEDICAL HISTORY</u> *Do you have now, or have you ever had diseases or conditions of (please circle yes or no):*

Skin Cancer	Yes	No	Myasthenia Gravis	Yes	No	Amyotrophic Lateral Sclerosis	Yes	No
Other Skin Disease	Yes	No	Hepatitis	Yes	No	Allergies to Bovine (Cow's Milk)	Yes	No
Problems with Skin Healing	Yes	No	Eye Disease	Yes	No	Fainting	Yes	No
Keloid Scars	Yes	No	Autoimmune Disease	Yes	No	Arthritis /Joint Deformity	Yes	No
Skin Rash /Medications	Yes	No	Vision Problems	Yes	No	Convulsions/Epilepsy	Yes	No
Skin Rash /Bandages	Yes	No	Numbness	Yes	No	Gastrointestinal Disorder	Yes	No
Skin Rash/Environment	Yes	No	Muscle Weakness	Yes	No	Lung Disease	Yes	No
Skin Rash /Food	Yes	No	Multiple Sclerosis	Yes	No	Liver Disease	Yes	No
Skin Rash/Other	Yes	No	Bell's Palsy	Yes	No	Kidney Disease	Yes	No
Bleeding Problems	Yes	No	Parkinson's Disease	Yes	No	Blood Clots	Yes	No
Swelling Hands/Feet	Yes	No	Neurological Disorder	Yes	No	Phlebitis	Yes	No
Diabetes	Yes	No	Lambert-Eaton Syndrome	Yes	No	Thyroid Problems	Yes	No
High Blood Pressure	Yes	No	Dizzy Spells	Yes	No	Asthma/Wheezing	Yes	No
Chest Pain	Yes	No	Heart Attack	Yes	No	Heart Murmur	Yes	No
Irregular Heartbeat Yes	No		Pacemaker	Yes	No	Pregnancy spots/mask	Yes	No
Easily Bruise	Yes	No	Heart Disease	Yes	No	Herpes Simplex	Yes	No
Hormone Imbalance	Yes	No	HIV/AIDS	Yes	No	Poly-Cystic Ovarian Disease	Yes	No

If yes to any of the above, please explain: ______________________________

Please list any other condition or disease: ______________________________

Please list any past hospitalizations: ______________________________

SOCIAL HISTORY:

Do you smoke? Yes No If yes, how much? ______________________________

Do you drink alcohol? Yes No If yes, how much? ______________________________

Have you ever been exposed to HIV (AIDS) or Hepatitis? Yes No

FAMILY MEDICAL HISTORY: ***If yes…***

Skin Cancer Yes No Relationship______________ Type of Cancer: ______________

Other medical problems? ______________ Relationship ______________

Type of problem: ______________________________

WOMEN ONLY:

Are you pregnant, trying to get pregnant, or lactating/nursing? Yes No

TREATMENT HISTORY:

Are you using Retin-A, Tazerac, Differin, Hydroquinone, or any other topical skin exfoliation or bleaching agent? Yes No

What is it (brand) and how often? ______________________________

Have you ever had plastic surgery to your face or neck areas? Yes No

If yes, please explain: ______________________________

Date of surgery: ______________________________

Have you ever had **Botox/Dysport/Xeomin** before? Yes No

If so, how long ago? ______________ Location of treatment: ______________

Were you happy with this treatment? Yes No

Explain: ______________________________

Have you ever had eyelid/eyebrow droop after **Botox/Dysport/Xeomin?** Yes No

Do you show a lot of upper lid when eyes are open? Yes No

Do your eyelids feel extra heavy when you don't get enough sleep? Yes No

Do your eyelids droop without sleep? Yes No

Special areas of concern for treatment? ______________________________

Have you ever had **injectable fillers, collagen, or collagen stimulators** before? Yes No

If so, how long ago? ______________ Location of treatment: ______________

Were you happy with this treatment? Yes No Explain______________

Special areas of concern for treatment? ______________________________

Have you ever had laser skin treatments or laser hair removal? Yes No

If yes, what and how long ago? ____

Have you ever used the following hair removal methods in the past month (please circle)?

Shaving Waxing Electrolysis Plucking/Tweezing Threading Depilatories

Have you ever had a chemical peel, microdermabrasion, or other skin resurfacing treatment? Yes No

If so, how long ago? ____

Have you ever been treated for pigmented lesions? Yes No

Do you form thick or raised scars from cuts or burns? Yes No

Do you experience hyperpigmentation (redness) from acne, burns, cuts, or insect bites? Yes No

Have you ever had cold sores or fever blisters? Yes No

Skin Type choices (when exposed to the sun for about 1 hour with no protection):

Check one

_____ Always burns, never tans _____ Rarely burns, always tans _____ Always burns, sometimes tans

_____ Brown, moderately pigmented skin _____ Sometimes burns, always tans _____ Black skin

I understand that the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur to my medical history/health I am responsible to report this to the office prior to any treatments. A current medical history is essential for my providers to execute treatment procedures. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I hade in the completion of this form.

Patient Signature: ____ **Date:** ________________________

Patient Signature: ____ **Date:** ________________________

Patient Signature: ____ **Date:** ________________________

Patient Signature: ____ **Date:** ________________________

Patient Signature: ____ **Date:** ________________________

Patient Signature: ____ **Date:** ________________________

Patient Signature: ____ **Date:** ________________________

Patient Signature: ____ **Date:** ________________________

Patient Signature: ____ **Date:** ________________________