DERMATOLOGY
OF EASTERN IDAHO
MEDICAL SPA

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PATIENT CONSULTATION AND HISTORY FORM

Patient's Name: ______________________ Today's Date: ______________

Address:____

City: ______________________ State: _____ Zip Code: ______________

Home Phone: (_______)____________ Cell: (_______)______________

Birth Date: _______/_______/_______

Would you like current specials sent to you? ☐YES ☐NO

Email address: ______________________________________

MEDICAL HISTORY

Are you experiencing any health problems? ☐ YES ☐NO

If yes, explain reason ______________________________________

Are you currently seeing a physician for any reason? ☐ YES ☐NO

If yes, explain reason ______________________________________

Do you have a pacemaker? ☐YES ☐NO

Have you ever seen a physician or technician specifically for a skin problem or skincare? ☐ YES ☐NO

If yes, explain reason ______________________________________

Are you currently under any other physician's or technician's care for your skin? ☐YES ☐NO

If yes, explain reason ______________________________________

Have you or any member of your family had skin cancer? ☐YES ☐NO

If yes, explain? ______________________________________

Anatomical location of cancer? ______________________________________

Have you or any family member ever had a skin lesion removed by a physician? ☐YES ☐NO

If yes, who had the lesion removed? ____________________ Anatomical location of lesion? __________________

Do you have any allergies or skin sensitivities? ☐YES ☐NO

If yes, list all allergies/skin sensitivities____

Do you currently take any oral medications (prescriptive pharmaceuticals)? ☐YES ☐NO

(Includes oral hormones, birth control pills, antibiotics, tranquilizers, diuretics, hypertension, etc)

If yes, list all oral medications ____

Do you use any topical medications (prescriptive pharmaceuticals)? ☐ YES ☐ NO

(Include Retin-A®, Hydroquinone, Accutane® Benzoyl Peroxide, Antibiotics, Metrogel®, Efudex®,

Cortisone, Glycolic Acid, Lactic Acid, Salicylic Acid, etc.)

If yes list all topical medications ____

Have you ever taken Accutane® ☐ YES ☐ NO

I currently take Accutane: Dosage prescribed __________________ Frequency taken ______________________

I took Accutane in the past: Date discontinued _________________ Dosage/frequency used________________

Have you ever had a "COLD SORE"? ☐ YES ☐ NO

If yes, when was your last cold sore? ____

Have you ever had a verruca vulagaris (warts)? ☐ YES ☐ NO

If yes, when was your last one, and at what location? ____

FREE RADICAL EXPOSURE

Do you smoke? ☐YES ☐NO If yes, how much/often? ______________________________________

Do you consume alcohol? ☐YES ☐NO If yes, frequency/amount _____________________________________

Do you have a healthy diet? ☐YES ☐NO List any dietary concerns ____________________________________

Do you exercise? ☐YES ☐NO If yes, how often? ____

Do you take vitamins? ☐YES ☐NO If yes, what type(s)? ____

Do you drink water? ☐YES ☐NO If yes, how many glasses per day? ____________________________

Do you experience any claustrophobia? ☐ YES ☐ NO

Circle your level of stress (1 low, 10 high):

1 2 3 4 5 6 7 8 9 10

WOMEN ONLY

Do you have regular periods? ☐YES ☐NO

Are you going through menopause? ☐ YES ☐NO

Are you trying to get pregnant? ☐ YES ☐ NO Are you in a fertility program? ☐YES ☐ NO

Are you pregnant or lactating? ☐ YES ☐ NO Have you ever been pregnant? ☐YES ☐ NO

If yes, during pregnancy did you ever experience hyperpigmentation or a "pregnancy mask"? ☐YES ☐NO

SKIN PRODUCT HISTORY

Do you currently use skincare products as a daily regimen? ☐YES ☐NO

If yes, list products used ____

Are you using sunscreen everyday? ☐YES ☐NO

At what temperature of water do you cleanse your face with? ______________________________

Have you done any aggressive exfoliation to your skin in the last 2 weeks? ☐YES ☐NO

If yes, explain type (S) of exfoliation ____

Have you ever had any enzyme or chemical peels? ☐YES ☐NO

Have you ever had a microdermabrasion treatment? ☐YES ☐NO

Have you ever had Intense Pulse Light treatments;(acne, hair removal, pigment)? ☐YES ☐NO

Have you ever had facial plastic surgery? ☐YES ☐NO

Have you ever had any Injectables? ☐YES ☐NO

☐Botox ☐Radiesse ☐Juvederm ☐Other

SUN HISTORY

Have you been in the sun lately? ☐ YES ☐NO

If yes, when? ____

Are you going on vacation any time soon? ☐ YES ☐NO

If yes, when? ____

In the past have you lived in a Sunbelt and sunbathed? ☐YES ☐NO

In the past have you neglected to use sunscreen? ☐YES ☐NO

Do you go to a tanning salon? ☐ YES ☐NO

What amount of time do you spend in the sun in the summer:

☐½ HR ☐ 1HR ☐2HRs or more

Do you have? ☐Birthmarks ☐Freckles ☐Redness ☐Pregnancy Mask

SKIN TYPE

Do you have broken capillaries? ☐YES ☐NO

If yes, where? ____

Do you blush easily? ☐ YES ☐NO

Have you been told you have Rosacea? ☐YES ☐NO

Does your skin appear sensitive? ☐YES ☐NO

Do you form thick or raised scars (keloid scarring)? ☐ YES ☐NO

Do you ever use depilatories or waxes on your face? ☐ YES ☐NO

If yes, when last used? ____

Does you skin ever flake or feel tight and dry?

☐Frequently ☐Occasionally ☐Rarely

Is your skin ever shiny a few hours after cleansing?

☐Frequently ☐Occasionally ☐Rarely

How often do you experience blackheads or blemishes?

☐Frequently ☐Occasionally ☐Rarely

What type of blemish do you get?

☐White heads ☐Black heads

What skin type do you consider yourself to have?

☐Oily ☐Acneic ☐ Combination ☐Normal ☐Mature

☐Dry ☐Sensitive

FITZPATRICK CLASSIFICATION SYSTEM (Please check one skin type below which best suits)

Skin Type:	**Skin Color:**	**Characteristics:**
☐ I	White	Always burns, never tans
☐ II	White	Usually burns, tans less than average
☐ III	White	Sometimes mild burns, tans about average
☐ IV	White	Rarely burns, tans more than average
☐ V	Brown	Rarely burns, tans profusely
☐ VI	Black	Never burns, deeply pigmented

PATIENT OBJECTIVE

What specific areas do you want to treat and why? (Please check all that apply and be specific.)

☐ Face ____

☐ Eyes ____

☐ Cheeks ____

☐ Neck ____

☐ Chest ____

☐ Back ____

☐ Hands ____

☐ Forearm____

☐ Other

What Services Would You Like To Learn More About? (Please check all that apply)

- ☐ Advanced Exfoliating
- ☐ Anti-Aging
- ☐ Hair Removal
- ☐ Skin Tightening
- ☐ Acne Treatments
- ☐ Facials
- ☐ Injectables
- ☐ Medical Grade Mineral Make-up
- ☐ Medical Grade Home Care Products
- ☐ Fractional Ablative CO_2
- ☐ Tatoo Removal