

PACIFICA INTEGRATIVE SKIN WELLNESS INSTITUTE

Monica Scheel, MD – Medical Director

MEDICAL HISTORY FOR COSMETIC TREATMENTS

Last Name _____ First Name _____

Date of Birth _____ Age _____ Email _____

Home Phone _____ Cell _____ Work _____

Number we can confirm an appointment? H C W Number to leave a message? H C W

Family Doctor _____ Phone _____

Pharmacy _____ Phone _____

Emergency Contact _____ Phone _____

Reason(s) for consultation...circle what bothers you the most: *redness, blood vessels, brown (sun) spots, wrinkles, texture, acne, blackheads, scars, precancers, dull appearance, skin tone, blotchiness, frown lines, folds around nose/mouth, neck, chest, hands, hair, other* _____

Previous Cosmetic Treatments, circle: *facials, microdermabrasion, chemical peels, laser, intense pulsed light, photodynamic therapy, hair removal, CO2 resurfacing, facelift, blepharoplasty, brow lift, visia photos, botox, restylane or other fillers, fractional light, other* _____

Satisfaction, side effects and other results from previous treatments:

Current skin care regimen/products used: *sunscreen SPF __ Brand _____ Daily use? y/n, Sunscreen only when outside? y/n, cleanser, moisturizer, anti-aging products, fade creams, lighteners, Retin A, Retinol, Vitamin C, Glycolic acids, firming creams, other* _____

AM Regimen _____

PM Regimen _____

Do you have ANY current or chronic medical illnesses that we should know about? Y/N

Please list _____

Do you have ANY allergies to medications, foods, latex, or other substances? Y/N

Please list _____

Do you take/use ANY medications, both prescription and non-prescription, herbal or natural supplements, or topicals on a regular or daily basis? Y/N

Please list _____

HISTORY QUESTIONNAIRE

- Y/N Do you have a history of 'cold sores', herpes I or II, hepatitis type _____?
- Y/N Do you have a history of diabetes, hypertension, cholesterol, or problems with wound healing?
- Y/N Do you have any sensitivity to heat, get heat rash or hives?
- Y/N Do you have any history of seizures?
- Y/N Do you have a history of migraine headaches?
- Y/N Do you have a history of keloid or hypertrophic scarring or abnormal scarring?
- Y/N Do you have any active infections or compromised ability to healing?
- Y/N Do you take St. John's Wort or any anticoagulants?
- Y/N Do you have any permanent make-up, implants, or tattoos?
- Y/N Do you have any open lesions in the area to be treated?
- Y/N Have you taken Accutane in the last 6 months?
- Y/N Have you had or are you undergoing any treatments for cancer? Type _____
- Y/N Have you used any exfoliating creams or products (*Retin A, Differin, Glycolic Acid, Alpha-Hydroxy acid products*) in the last 2 weeks?
- Y/N Have you had mechanical epilation (plucking, tweezing, electrolysis, sugaring) less than 4 weeks ago?
- Y/N Have you had any unprotected sun exposure, used self-tanning creams or tanning beds in the last 4-6 weeks in the area to be treated?
- Y/N Are you sensitive to sunscreens or anti-aging creams?

Women:

- Y/N Are you or could you be pregnant?
- Y/N/NA Are your periods regular?

To avoid misunderstandings please carefully read our Financial Policy. Cosmetic appointments require a 25% deposit on your procedure to schedule. The balance is due after your first treatment. If you miss or cancel your appointment with less than 24 hours notice, you will be billed a \$50 cancellation fee and be required to leave a credit card number to rebook. There is a \$25 check return fee. Your signature below indicates you understand and accept our policy, and the information contained in this document is correct.

Signature _____ Date _____