D/S

DERMATOLOGY BY SHELLY

COSMETIC MEDICAL HISTORY FORM

Last Name: _____ First Name: _____

DOB: _____/_____/_____ Female _____ Male _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

Preferred Phone: _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Which body area/areas or condition would you like treated?

_____

_____

Please answer all of the following questions	**YES**	**NO**
1. Do you have **ANY** current or chronic medical illnesses?	□	□

Disclose any history of heat urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness.

Please List:

_____

_____

2. Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition. **Please List:**

_____

_____

3. Are you currently under a doctor's care? If so, for what reason? □ □

_____

4. Do you take/use **ANY** medications (prescription and nonprescription), vitamins, herbal or natural supplements, on a regular or daily basis? **YES** ☐ **NO** ☐
Please List:

_____

5. Have you ever had Gold Therapy Treatment (chrysotherapy, aurotherapy, Gold sodium thiomalate (GST)? ☐ ☐

_____

6. Are there any topical products (both medical and non-medical, over the counter products) that you use on your skin on a regular or daily basis? ☐ ☐
Please List:

_____

_____

7. Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)?

☐ ☐

8. Do you have **ANY** allergies to medications, foods, latex or other substances?

☐ ☐

Please List: _____

9. Do you have a history of herpes I or II in the area to be treated? ☐ ☐

10. Do you have a history of keloid scarring or hypertrophic scar formation? ☐ ☐

11. Do you have a history of light induced seizures? ☐ ☐

12. Do you have any open sores or lesions? ☐ ☐

13. Do you have any history of radiation therapy in the area to be treated? ☐ ☐

14. In the last six (6) months, have you used any of the following: ☐ ☐
Anticoagulants (blood-thinning medications), anti-inflammatories or photosensitizing medications? If so, please List product name and date last used:

_____

_____

_____

15. In the last three (3) months, have you used any of the following products: **YES** **NO**

glycolic acid or other alpha hydroxy or beta hydroxy acid products, exfoliating or resurfacing products or treatments? ☐ ☐
Please List product name and date last used:

_____

16. Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers, including, but not limited to, collagen, autologous fat, Restylane®, Juvaderm etc.? ☐ ☐

If yes, please list locations on or in the body and dates:

_____

_____

17. Do you have or have you ever had any toxin such as Botox® or Dysport®? ☐ ☐

If yes, please list locations on or in the body and dates:

_____

_____

18. Have you taken Accutane® (or products containing isotretinoin) in the last 12 months? When was your last dose? _____ ☐ ☐

19. Have you used Tretinoin (like Retin-A, Renova) in the last 6 months? ☐ ☐

20. Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks? ☐ ☐

21. **Women Only**

Are you or could you be pregnant? ☐ ☐

Are your menstrual periods regular? N/A ☐ ☐ ☐

Have you ever been diagnosed with Polycystic Ovarian Disorder? ☐ ☐

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

D/S

DERMATOLOGY BY SHELLY

Client Name:_____ Date:_____ Score:_____

	0	1	2	3	4
What is your eye color?	Light blue or gray	Blue or green	Hazel, Light brown	Dark brown	Brownish black
What is the natural color of your hair?	Red, Sandy red	Blonde	Dark blonde, Chestnut brown	Dark brown	Black
What is the color of your skin (unexposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had burns
To what degree do you turn brown?	Hardly any or not at all	Light tan	Reasonable tan	Tan very easily	Turn dark brown quickly
Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
When did you last expose yourself to the sun, tanning bed or self-tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
How often is the area you want to have treated exposed to the sun?	Never	Hardly ever	Sometimes	Often	Always

Add above for Total score:	Match your total score with the corresponding Skin Type.	Fitzpatrick Skin Type:
	0-7	I
	8-16	II
	17-25	III
	26-30	IV
	Over 30	V-VI

Skin Type I

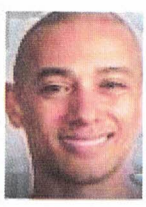
Fair skin, red or blonde hair, blue/ green eyes, never tans, always burns.

Skin Type II

Fair skin, sandy - light brown hair, green or brown eyes, occasionally tans, usually burns.

Skin Type III

Medium skin, brown hair, brown eyes, often tans, sometimes burns.



Skin Type IV

Olive skin, brown / black hair, brown / black eyes, always tans, never burns.

Skin Type V

Dark skin, black hair, black eyes, never burns.

Skin Type VI

Black skin, black hair, black eyes, never burns.

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