INTEGRATED MEDICINE & Aesthetics

PATIENT HISTORY AND PHYSICAL

Patient Name: _____ Date: _____

Date of Birth: _____ Occupation: _____

Address: _____

Cell Phone: _____ Home Phone: _____

Emergency Contact name and phone: _____

MEDICAL HISTORY:

Do you have any of the following medical conditions (please check those that apply):

- ☐ Cardiac Problems (*e.g.*, pacemaker or defribillator)
- ☐ Bleeding Disorders (bruise easily)
- ☐ Daily use of anticoagulants or aspirin
- ☐ Diseases stimulated by light (*e.g.*, Epilepsy)
- ☐ Diseases stimulated by heat (Herpes Simplex)
- ☐ Skin disorders or skin lesions
- ☐ Hormone imbalance (*e.g.*, PCO)
- ☐ Melasma / PIH
- ☐ Autoimmune disorder (*e.g.* Lupus, HIV/AIDS)
- ☐ High Blood Pressure
- ☐ Keloids/scarring
- ☐ Impaired healing
- ☐ Cancer
- ☐ Frequent cold sores
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Thyroid disorder

Please explain if you checked any of the above:

_____

MEDICATIONS:

Have you ever used Accutane for acne treatments? ☐No ☐Yes Dates Used: _____

Please list all Prescription Medications you are currently taking: _____

_____

Please list all OTC medications and supplements you are currently taking: _____

_____

Have you ever had an allergic reaction to the following (please check those that apply) :

☐ Latex ☐ Lidocaine ☐ Anesthesia ☐ Topical Anesthetic ☐ Other

Please explain: _____

Female Patients: ☐ Are you pregnant? ☐ Are you breast feeding?

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Surgical History (incl. cosmetic) – please list all surgeries with the year that they were performed:

_____

Cosmetic Treatment History – please list all treatments with the year that they were performed:

_____

Are you under the care of a physician or dermatologist at this time? ☐Yes ☐No

Do you smoke? ☐Yes ☐ No Do you drink alcohol? ☐Yes ☐No

SKIN TYPE

Ethnicity: Please check all that apply (even if you are a combination of the below).

☐ White ☐ Asian ☐ Mediterranean

☐ Black ☐ Hispanic ☐ Middle Eastern

Which of the following describes best your skin reaction when you are in the sun?

☐ Always burn, never tan (Type I) ☐ Rarely burn, tan easily (Type IV)

☐ Burn easily, tan minimally (Type II) ☐ Rarely burn, tan profusely (Type V)

☐ Burn and tan moderately (Type III) ☐ Never burn, tan profusely (Type VI)

Are you tan now? ☐ No ☐ Yes ☐ from sun ☐ from tanning bed ☐ from tanning lotion

Will you be exposed to the sun in the near future? ☐ Yes ☐ No

Do you use sunscreen? ☐ Never ☐ Sometimes ☐ Always

What SPF do you use? _____ How often do you apply your sun screen during the day? _____

Do you have any problems with hyperpigmentation (dark skin coloration) or hypopigmentation (light skin discoloration)? ☐ No ☐ Yes Location: _____

What skin care products do you use? _____

Have you had any injections or fillers in the area to be treated? If so, please specify:

_____

Do you have any tattoos (incl. permanent makeup)? ☐ No ☐ Yes

If yes, location: _____

Do you have any moles, birth marks or any other dark lesions? ☐ No ☐ Yes

If yes, location: _____

When where these lesions last checked by a physician? _____

_____ _____

Patient Signature Date

Disclaimer: This clinical form is presented for information purposes only. This document cannot and should not be used as a basis of diagnosis or choice of treatment, and is not intended to replace professional medical care or attention by a qualified practitioner.

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