

PATIENT INFORMATION

DATE: _____ NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE:(home) _____ (work) _____ (cell) _____

E-MAIL: _____ DATE OF BIRTH: ___ / ___ / ___ AGE: ___ S/S/N ___ - ___ - ___

EMERGENCY CONTACT: _____ PHONE: _____

MARITAL STATUS: (SINGLE) (MARRIED) (DOMESTIC PARTNER)(DIVORCED)(WIDOWED)

LIST ANY MEDICATION YOU CURRENTLY TAKE: _____

HAVE YOU USED ACCUTANE IN THE LAST TWELVE MONTHS (Yes or No)?

PLEASE LIST ANY SERIOUS OPERATIONS: _____

PLEASE LIST ANY SERIOUS ILLNESSES: _____

ARE YOU ALLERGIC TO ANYTHING? _____

DO YOU SMOKE? _____ IF YES, HOW MUCH? _____

HOW MUCH ALCOHOL DO YOU CONSUME IN A WEEK? _____

HOW WOULD YOU DESCRIBE YOUR SKIN TYPE? (CIRCLE ONE)

-NORMAL- -DRY- -OILY- -ACTIVE ACNE- -ACNE PRONE- - ADULT ACNE- -COMBINATION-

DO YOU HAVE SENSITIVE SKIN (Yes or No)? If yes, explain _____

DO YOU EVER HAVE SKIN RASHES (Yes or No)? If yes, explain _____

DOES YOUR SKIN TURN RED EASILY (Yes or No)? If yes, explain _____

HAVE YOU EVER HAD A SKIN PEEL (Yes or No)? If yes, explain _____

HAVE YOU EVER USED PRODUCTS THAT CONTAINED ACID (Yes or No)?

WHAT OTHER SKIN TREATMENTS HAVE YOU HAD? _____

WHAT WOULD YOU LIKE TO CORRECT OR IMPROVE ABOUT YOUR SKIN? _____

SIGNATURE _____