SKIN RENAISSANCE
CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatments we need you to complete the following questionnaire. All information is strictly confidential. Thank you!

PERSONAL HISTORY

Client Name ____ Today's Date ________________

Date of Birth __________________ Age ________ Occupation _______________________________

Home Address _________________________ City ______________ State ______ Zip _____________

Home Phone ( ) ____________ Work Phone ( ) _____________ Cell Phone ( ) ______________

E-Mail ______________________________ How were you referred?___________________________

Emergency Contact Name and Phone ____

Which of the following best describes your skin type? (Please circle one type number)

I Always burns, never tans
II Always burns, sometimes tans
III Sometimes burns, always tans
IV Rarely burns, always tans
V Brown, moderately pigmented skin
VI Black skin

What brings you in to see us today? ____

What are some of your concerns/areas of interest? Please **circle** **WRINKLES AGING SKIN ACNE SPIDER VEINS FACIAL FOLDS/LINES LASER HAIR REMOVAL SUN DAMAGE SKIN TEXTURE/TONE FATIGUE SKIN LAXITY ROSACEA EXCESSIVE SWEATING TEETH GRINDING MIGRAINES OTHER ____________________**

MEDICAL HISTORY

Are you currently under the care of a physician? __ Yes__No Name______________________________

If yes, for what? ____
____

Are you currently under the care of a dermatologist? __ Yes __ No Name__________________________
If yes, for what? ____
____

Do you have a history of **erythema abigne**, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? _____ Yes _____ No

Do you have any of the following medical conditions? (Please check all that apply)

____ Cancer _____Heart problem ____ Diabetes ____ High blood pressure ____ Herpes ____ Arthritis
____ Frequent cold sores ____ HIV/AIDS _____ Keloid scarring _____ Skin disease/Skin lesions
____ Seizure disorder ____ Hepatitis _____Hormone imbalance _____ Thyroid problem
____ Blood clotting abnormalities _____ Any active infection ____ Blood clots ____ Rosacea
____ALS/Lambert-Eaton Syndrome _____Vitiligo _____Myasthenia Gravis
____Other neurological disorder ____Fever/night sweats _____ Unexplained Weight Loss
Other____

Please explain above checked items

____
____
____
____

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced) ____ Food ____ Latex ____ Aspirin ____ Lidocaine ____ Hydrocortisone ____ Hydroquinone or skin bleaching agents ____Albumin Others: ______________________________

____

MEDICATIONS

What oral medications are you presently taking? __ Birth control pills__ Hormones __Blood Thinners ____ Others (Please list) ____

Herbal/Vitamin supplements____ Are you on any mood altering or anti-depression medication? __________________________________

Have you ever used Accutane? ____ Yes ____ No. If yes, when did you last use it? ________________

What topical medications or creams are you currently using? ____ Retin-A ____ Others (please list):

____

List any facial products and SPF used at home: ____

Do you wear sunscreen daily? ___Yes ___No

HISTORY

Have you ever had laser hair removal?___ Yes __ No When?____________ Where?________________

Have you used any of the following hair removal methods in the past six weeks?

____ Shaving ____ Waxing ____ Electrolysis ____ Plucking ____ Stringing____ Depilatories

Have you had any dermal fillers? ___Yes ___No When?___________ Where?______________________

Have you ever had Botox/Dysport? ___Yes ___ No When? ___________ Where?__________________

Have you had any other laser procedures? ___Yes ___No When?__________ What?_________________

Have you had any recent tanning or sun exposure that changed the color of your skin? ____ Yes ____ No

Have you recently used any self-tanning lotions or treatments? ____ Yes ____ No

Do you use tanning booths/salons? ___Yes ___No How frequently?______________________________

Do you form thick or raised scars from cuts or burns? ____ Yes ____ No

Do you have any Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ____ Yes ____ No If yes, please describe: _______________________

____

Have you had any facial surgery or cosmetic surgery? Please explain ______________________________

____

Are you interested in a Complimentary Consultation with our Plastic Surgeon ____Yes ____ No

Area of Interest:____

For our female clients:

Are you pregnant or trying to become pregnant? ____ Yes ____ No Are you breastfeeding? ____ Yes ____ No Are you using contraception? ____ Yes ____ No

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature of client ____ **Date** ________________

RN Signature ____ **Date**______________________

Esthetician Signature _______________________________________ **Date**_____________________

☐ **Robert Schnarrs, MD** ____________________ ☐ **Laura Currence, FNP-c** ___________________

☐ **Suzanne Adcook, CPNP**___________________