



**Patient Profile – Medical History**

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell/Alt. Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Emergency Contact (Name & Phone): \_\_\_\_\_

How did you hear about Greenwich MedSpa and/or who referred you: \_\_\_\_\_

*(Please use the back of this form if the space provided anywhere is insufficient)*

**1. Have you ever had or have been treated for: (“X” all that apply)**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> AIDS/ARC            | <input type="checkbox"/> allergy/hay fever   | <input type="checkbox"/> dizziness/fainting spells     | <input type="checkbox"/> epilepsy                |
| <input type="checkbox"/> skin rash/disease   | <input type="checkbox"/> asthma or wheezing  | <input type="checkbox"/> head injury                   | <input type="checkbox"/> eye injury or disease   |
| <input type="checkbox"/> heart trouble       | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> neuritis (nerve inflammation) | <input type="checkbox"/> swollen/painful joints  |
| <input type="checkbox"/> cancer              | <input type="checkbox"/> tuberculosis        | <input type="checkbox"/> mitral valve prolapse         | <input type="checkbox"/> rheumatism/arthritis    |
| <input type="checkbox"/> diabetes            | <input type="checkbox"/> varicose veins      | <input type="checkbox"/> drug or alcohol addiction     | <input type="checkbox"/> tendonitis              |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> phlebitis of vein   | <input type="checkbox"/> frequent severe headaches     | <input type="checkbox"/> bone or joint deformity |
| <input type="checkbox"/> bleeding problems   | <input type="checkbox"/> back problem/pain   | <input type="checkbox"/> nervousness                   | <input type="checkbox"/> ankle/feet swelling     |

**2. List other diseases or illnesses you have had:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**3. List all prescription and non-prescription medication you are currently taking or have recently taken: (“X” all that apply)**

- |   |  |                                  |
|---|--|----------------------------------|
| <input type="checkbox"/> Heart                                      | <input type="checkbox"/> Blood Pressure          | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Insulin or other diabetic medications      | <input type="checkbox"/> Tazorac                 |                                  |
| <input type="checkbox"/> Cold / Allergy medications                 | <input type="checkbox"/> Testosterone / estrogen |                                  |
| <input type="checkbox"/> Tranquilizers / Anti-depressants           | <input type="checkbox"/> Antibiotics             |                                  |
| <input type="checkbox"/> Herbal / Nutritional supplements           | <input type="checkbox"/> Vitamins                |                                  |
| <input type="checkbox"/> Retin-A / Renova / Differin / Hydroquinone |  |                                  |
| <input type="checkbox"/> Accutane – when stopped:                   | _____  |                                  |

List others: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**4. List below all hospitalizations for illnesses, operations, accidents or fractures:**

Year: \_\_\_\_\_ Reason: \_\_\_\_\_

Year: \_\_\_\_\_ Reason: \_\_\_\_\_

Year: \_\_\_\_\_ Reason: \_\_\_\_\_

Year: \_\_\_\_\_ Reason: \_\_\_\_\_

**6. Primary Physician: (Name and Telephone)**

\_\_\_\_\_

\_\_\_\_\_

Date of Last Physical? \_\_\_\_\_

**8. Pharmacy Telephone:** \_\_\_\_\_

**5 Do you drink alcohol? Do you smoke?**

- |  |   |
|--|---|
| <input type="checkbox"/> No                  | <input type="checkbox"/> No                       |
| <input type="checkbox"/> 1-2 drinks per week | <input type="checkbox"/> Less than 1 pack per day |
| <input type="checkbox"/> 3-5 drinks per week | <input type="checkbox"/> 1 pack per day           |
| <input type="checkbox"/> 5+ drinks per week  | <input type="checkbox"/> More than 1 pack per day |

**7. When you go to the dentist:**

Do you require antibiotics be used? Y / N

Do you require extra numbing medication? Y / N

Patient Name: \_\_\_\_\_

**9. WOMEN ONLY:**

Are you pregnant? Y / N Due Date: \_\_\_\_\_

Date of your last menstrual period: \_\_\_\_\_

Are you currently lactating? Y / N

**10. Additional Questions:**

Do you wear contacts? Y / N

(you may have to remove them for treatment)

**11. Previous Cosmetic Procedures: (“X” all that apply)**

Do you currently get/use:  Facials / Peel  Waxed  Electrolysis  Depilatories  Microdermabrasion

Describe type(s), frequency & reaction(s): \_\_\_\_\_

\_\_\_\_\_

Have you ever had laser resurfacing? Y / N When, Type & Depth? \_\_\_\_\_

Describe your reaction: \_\_\_\_\_

Have you had collagen/dermal filler injection(s)? Y / N When & Type? \_\_\_\_\_

Describe your reaction: \_\_\_\_\_

Have you had a Botox injection(s)? Y / N When/Frequency? \_\_\_\_\_

Describe your reaction: \_\_\_\_\_

Have you recently had facial or cosmetic surgery? Y / N When? \_\_\_\_\_

Describe: \_\_\_\_\_

**12. Allergies:**

Are you allergic/sensitive to? (“X” all that apply)

Lidocane  Adhesives  Latex  Aspirin  Perfumes  Milk  Eggs  Hydroquinone

Mushrooms  Apples  Grapes  Citrus  Aloe Vera  Alcohol based products: \_\_\_\_\_

Other: \_\_\_\_\_

List other allergies to any medication: \_\_\_\_\_

Have you every used any products that caused a bad reaction? Y / N

If yes, describe: \_\_\_\_\_

Have you ever seen a dermatologist or other physician for your skin? Y / N

If yes, describe: \_\_\_\_\_

Have you ever had a skin allergy or sensitivity? (Rash, irritation, peeling, swelling, hives, etc.)? Y / N

If yes, describe: \_\_\_\_\_

**13. Skin Description: (“X” all that apply)**

Describe your skin:  Thick  Thin  Loose  Firm  Freckled

Uneven/blotchy  Normal  Dry  Oily  Mature  Wrinkled

Melasma (mask of pregnancy)  Rosacea  Eczema  Psoriasis  Sun-damaged

Hyper-pigmented (excess pigment)  Hypo-pigmented (lack of pigment)  Acne

Dehydrated (lack of moisture)  Patchy dryness on \_\_\_\_\_

Do you consider yourself:  Sensitive to touch or pain  Tolerant  Resilient  Not Sure

Skin tone:  Pale/White  Light  Medium  Reddish  Freckled  Lt. Olive

Med. Olive  Dark Olive  Lt. Brown  Med. Brown  Dark Brown  Soft Black  Black

Describe your ethnic background? \_\_\_\_\_

Do you redden or flush easily when you eat spicy food, drink alcohol, get angry, go in the sun, etc.? Y / N

Patient Name: \_\_\_\_\_

**13. Skin Description: CONTINUED**

**FITZPATRICK SCALE:** How do you tan? (“X” only one, if you do not know, please review with clinician)

- I Burn     II Usually Burn     III Sometimes Burn     IV Rarely Burn     V Never Burn

**Pigmentation:**     Even     Uneven     VI Never Burn/Black

**Telangiectasia** (broken capillaries): Do you have this condition? Y / N    If yes, where:

- Nose area     Cheek area     Chin area     Forehead     Entire Face

**Acne:** If yes above for Acne, or you have a history of acne or breakouts, which one(s) apply?

- Pimples     Whiteheads     Blackheads     Enlarged Pores     Acne Scars     Cysts     Flakiness

**Skin Type:**

- Does your skin ever flake or feel tight and dry?     Frequently     Occasionally     Rarely  
Is your skin ever shiny a few hours after cleansing?     Frequently     Occasionally     Rarely  
How often do you experience breakouts?     Frequently     Occasionally     Rarely  
How noticeable are your pores?     Very     T-Zone     Not very

**Ability to Heal:**

Does your skin appear fragile or burn easily? Y / N    If yes, describe: \_\_\_\_\_

Do you have any problems healing from a cut or burn? Y / N    If yes, describe: \_\_\_\_\_

Have you ever had a “cold sore”? Y / N    If yes, describe: \_\_\_\_\_

**Sun History and Lifestyle:**

Do you work primarily inside? Y / N    Occupation: \_\_\_\_\_

Are your hobbies done mostly outside? Y / N    Hobbies: \_\_\_\_\_

In the past have you neglected to use sunscreen? Y / N    If yes, describe: \_\_\_\_\_

Are you in the habit of going to tanning booths? Y / N    If yes, describe: \_\_\_\_\_

Do you currently use sun block regularly? Y / N    Are you currently sunburn/windburn/red faced? Y / N

Describe your daily home care regimen? \_\_\_\_\_

HAVE YOU OR ANYONE IN YOUR FAMILY HAD SKIN CANCER? Y / N    If yes, describe: \_\_\_\_\_

**14. Desired improvements:**

Current appearance problems / goals that brought you to the Greenwich Medspa: \_\_\_\_\_

Appearance wish list (anything about your appearance that you wish you could change or improve): \_\_\_\_\_

What non-surgical cosmetic medical procedures would you like to learn more about? (“X” all that apply)

- Botox     Dermal Fillers (Restylane, Hylaform, Collagen, etc.)     IPL Permanent Hair Reduction  
 IPL Skin Rejuvenation (Photofacial, Pigmented Lesions, etc.)     Facial     Exfoliating Peel  
 Microdermabrasion     Vein Therapy     Other (Acne, Cellulite, etc.): \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician Signature

\_\_\_\_\_  
Date

**This is a confidential report of your medical history and will be kept in this office. Information contained herein will not be released to any person or organizations except when you have authorized us to do so.**