THE GREENWICH MEDICAL SKINCARE & LASER SPA

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)**

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

☐ Heart ☐ Blood Pressure ☐ Thyroid

☐ Insulin or other diabetic mediations ☐ Tazorac

☐ Cold / Allergy medications ☐ Testosterone / estrogen

☐ Tranquilizers / Anti-depressants ☐ Antibiotics

☐ Herbal / Nutritional supplements ☐ Vitamins

☐ Retin-A / Renova / Differin / Hydroquinone

☐ Accutane – when stopped: _____

List others: _____

_____

_____

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

Year: _____ Reason: _____

_____

Year: _____ Reason: _____

_____

Year: _____ Reason: _____

_____

Year: _____ Reason: _____

_____

5 **Do you drink alcohol?**

☐ No

☐ 1-2 drinks per week

☐ 3-5 drinks per week

☐ 5+ drinks per week

Do you smoke?

☐ No

☐ Less than 1 pack per day

☐ 1 pack per day

☐ More than 1 pack per day

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

_____

_____

Date of Last Physical? _____

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

Do you require antibiotics be used? Y / N

Do you require extra numbing medication? Y / N

8. **Pharmacy Telephone**: _____

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 ☐ VI Never Burn/Black

Pigmentation: ☐ Even ☐ Uneven

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.