



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.