TOC MedicalSpa

Patient Health History

Name _____ **Date**_____

Do you have or have you had any of the following:

Blepharoplasty	Eye Surgery or injury	Neurological Diseases	Pregnancy
Silicone Injections	Thyroid (over/under)	Cancer	Ocular Disorders
High/Low blood pressure	Heart problems	Metabolic Disorders	Muscle Disorders
Chemotherapy/Radiation	Tumors/growths/cysts	Hepatitis	HIV

Do you smoke? Yes No

Please list any drug allergies that you have: _____

Please list any major illnesses/chronic conditions: _____

Please list any major hospitalizations: _____

Please list any family history of skin cancer: _____

Please list outdoor activities: _____

How much sun exposure do you get in an average week? _____ Hours

Do you use tanning booths? Yes No Do you use SPF? Yes No If yes, what SPF level? _____

Circle all that apply to your skin (past or present):

Acne Pimples Broken Capillaries/area: _____ Enlarged Pores

Are you pregnant? Yes No Are you breastfeeding? Yes No

Have you had any facial reconstructive/cosmetic surgery? Yes No

If yes, please specify: _____

Do you get cold sores or fever blisters? Yes No If yes, how often? _____

Have you had facial waxing/electrolysis? Yes No If yes, how long ago? _____

Have you used any of the following? Accutane Retin A Birth Control Pills

If using Accutane: When was your last dose?_____ If using RetinA: How long ago? _____

Strength of RetinA: .1% .05% .025% Renova Tazorac Avage Other: _____

Please list any oral or topical medications/products you are using on a regular basis (include prescription, over the counter, vitamins, natural supplements): _____

Have you seen a dermatologist in the past five years? Yes No

What product(s) do you currently use? Cleanser Toner Moisturizer Scrubs Masques Sunscreen

Sunscreen Brand: _____

How much water do you drink per day? _____ 8 oz. glasses

How many caffeinated beverages do you consume in a day? (coffee, tea, soda, etc.) _____

Who referred you to our practice: _____