SKIN INSTITUTE
DENVER

Skin Institute Denver Health History Assessment

Date: _____ Patient Name: _____ DOB (age): _____

o Are you in the process of a name change? o Yes o No
-Have you had a name change? o Yes o No
If yes, please specify your full legal name, along with the date of change:
_____.
Kaiser Medical Record Number (#):_____.

Address (including apt #): _____City/State/Zip code:_____

Contact Info

Best number to contact: **Please fill in and initial.**
Upcoming appointments, as well as a good email address for us to send you a purchase receipt, and newsletters upon request.

o Mobile _____

o Home _____

o Work _____

Email Address: _____

Physician & Specialty: _____ Phone/extension: _____
(Doctor will only be notified when needed for further patient care upon patient authorization.)

ICE Contact: _____ Relationship: _____ Phone: _____

How did you find out about the *Skin Institute of Denver?* _____.

Are you willing to be compliant with your products and treatments?

o Yes o No – If yes, please initial: _____.

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year? o No o Yes

If yes, please explain:_____.

2) Any recent surgery, including plastic surgery? o No o Yes
If yes, please explain: _____.

3) Any skin cancer? o No o Yes

If yes, please describe in detail:
_____

_____

_____.

4) Have you had any piercings, tattoos, or permanent cosmetics? o No o Yes
If yes, where?_____.

5) Do wear contacts? (Hard or soft? Please circle the one that applies) o Yes o No
(Some treatments require the contacts to be removed for safety reasons.)

6) Have **you** had any of these health conditions in the past or present? (Please circle all that apply and provide additional information at the end of this form if needed.

Skin	**Systemic**	**Neurological**
Acne	High Blood Pressure	Seizures/ Epilepsy
-Ingrown hair follicles	Thyroid Condition	Stoke / Bell's Palsy
-Eczema/Psoriasis	Arthritis	Clotting Disorders/blood thinners
-Lesions/cysts	Diabetes	Headaches / Migraines
-Milia/White Heads	Hormone imbalance	Vertigo / Ringing in Ears
-Black Heads	Hormone Therapy	Lupus / Immune Disorder
Broken Capillaries	HIV / AIDS	Memory Problems
-Vericose Veins	Hepatitis	Psychological Problems
Hyperpigmentation	Elevated Cholesterol	-Anti-Depressants
-Melasma	Elevated Liver Enzymes	
-Linea Nigra	Bowel Problems	
Hypopigmentation	Heart Problems/Pacemaker	
Vitiligo	Asthma	
Keloid Scars	Multiple Sclerosis	
Herpes / Cold Sores		
Triggered by heat or stress.		

Other: _____.

Surgeries – Past _____.

Surgeries – Pending_____.

7) Excessive weight loss and/or weight gain within the past year? o Yes o No

8) What is your pain tolerance: o Mild o Moderate o Extensive

9) Do you smoke? o No o Yes

If yes:
Consumption per day? _____.
Nicotine patch/Nicorette gum or any other substitute? o Yes o No

10) What is your stress level? o Low o Medium o High

11) List any medications you take regularly; including over the counter medications, supplements and prescribed dosage:
_____

_____.

12) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin A derivative products? o No o Yes

- Have you used any of these in the last 3 months? o No o Yes

13) Have you ever used an acne medication (i.e. Acutane)? o No o Yes

If yes, when? _____Medication? _____ Dosage: _____

Are you still taking this medication? o Yes o No

14) Do you form thick or raised scars from cuts or burns? o No o Yes

If yes, please describe:
_____

_____.

15) Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? o No o Yes

If yes, please describe:
_____

_____.

16) Have you used a tanning bed in the last 48 hours? o No o Yes

-How frequently are you exposed to the sun or use a tanning bed? (Driving doesn't apply) (Mark an 'x' by what describes you most)____Infrequently ____Frequently ____Regularly

-Do you burn easily? o No o Yes

17) Ever had a bad reaction to laser or chemical peel? o No o Yes

If yes, please explain in detail:
_____

_____.

18) Hereditary background/ skin tone: _____.

19) Have you ever had an adverse reaction after using any skin care product? o Yes o No
(If yes, please circle any that apply) Rash, Irritation, Burn, Peeling, Sun Sensitivity, Breakout.

-Are you allergic to certain sunscreens, fragrances, Aspirin, Sulfur/Sulfa, AHAs and/or citrus? o Yes o No

If yes, please describe :_____.

-Do you carry an epi-pen? o Yes o No

20) Have you ever had an allergic reaction to any of the following? o Yes o No
(Please circle any that apply) Medicine, Food, Animals, Iodine, Xlyocaine, Pollen, Shellfish, Latex, Drugs, Other:
_____

21) How would you describe your skin? What are your concerns, and what are you looking to achieve after your first initial visit with us?
_____

_____.

22) Please list your skin regimen, along with what product lines you're using, and mark when you use these products. (AM/PM)

Cleanser: _____.
Toner: _____.
Exfoliant: _____.
Moisturizer: _____.
Sunscreen: _____.

Female & SRS Patients:

1) Are you taking any contraceptives, including oral? o No o Yes

If yes, please provide specific details including dosage, brand/name of contraceptive, and length of time that medication has been taken, as well as provide any details on any fertility treatments that you are currently taking part in.

_____

_____.

2) Are you pregnant, or trying to become pregnant? o No o Yes
-Are you lactating? o Yes o No

3) Any menopause problems? o No o Yes
If yes, please explain: _____.

If there was insufficient space on a question, please write the number of the question(s) and use the lines provided to write out your answer.

_____

_____

_____

_____

_____.

If there were any questions that you were unable to answer in this confidential health assessment, please feel free to ask us when you visit our office for your appointment.

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician/skin care professional of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____