Compass Customized Health & Wellness
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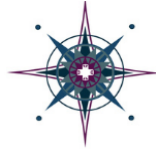

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SKIN HEALTH - MEDICAL HISTORY

Name:________________ Date of Birth:__________ Age:______ Sex: F M Other______

Address:________________ City:__________ State:______ Zip:__________

Cell Phone: __________ Work Phone:__________ Email:______________

Emergency Contact Name:______________ Emergency Contact Phone:______________

Diagnosis: Please check if you are affected by, or have a diagnosis of any of the following:

- ☐ Asthma
- ☐ Auto-Immune Disease
- ☐ Bell's Palsy
- ☐ Blood/Clotting Disorders
- ☐ Cardiac Issues
- ☐ Depression/Anxiety
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fever Blisters/Cold Sores
- ☐ Headaches (chronic)
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Hormonal Imbalance
- ☐ Lambert-Eaton Syndrome
- ☐ Myasthenia Gravis
- ☐ Pins/Plates/Metal Bone
- ☐ Neurological Issues
- ☐ Pacemaker
- ☐ Skin Disease
- ☐ Thyroid Issues
- ☐ Urinary/Kidney Issues
- ☐ Other:__________

Female Patients (check all that apply)

Are your periods: ☐ Regular ☐ Irregular ☐ Menopausal ☐ Other: __________

Are you: ☐ Pregnant ☐ Breastfeeding ☐ Taking Oral Contraceptive ☐ Receiving Hormone Replacement Therapy

Medication:

Please list all medications you are currently taking (including herbal, over the counter, topical, oral, and supplemental):

____

____

____

Are you currently taking / using: ☐ Antibiotics ☐ Anti-Inflammatory Drugs ☐ Blood Thinners ☐ Chemotherapy ☐ Corticosteroids ☐ Immunotherapy ☐ Insulin ☐ Radiation Therapy ☐ Transplant Anti-Rejection Drugs ☐ Topical Creams (i.e., Azelaic Acid, Tretinoin, Retinoids, Antibiotic Creams, etc.)

Do you have any allergies to foods or medications? ☐ No ☐ Yes List Allergies: __________

____

Do you have allergies/sensitivities to:

☐ ***Check if No to all***

- ☐ Alcohol-Based Products
- ☐ Aloe Vera
- ☐ Aspirin
- ☐ Bee/Wasp Stings
- ☐ Bleaching Agents
- ☐ Bovine/Ovine
- ☐ Eggs
- ☐ Hydrocortisone
- ☐ Hydroquinone
- ☐ Latex
- ☐ Lidocaine
- ☐ Perfumes

Other: ______________________________

Personal History:

Smoke: ☐ Yes ☐ No Frequency/Number of Packs: __________

Drink Alcohol? ☐ Yes ☐ No Amount & Frequency:__________

Exercise: ☐ Yes ☐ No How Often:__________

Drink Caffeine Daily? ☐ Yes ☐ No **Servings Per Day:** Tea______ Coffee ______ Soda ______

Drink Water Daily? ☐ Yes ☐ No Approximate Amount:__________

Sunbathe or Use Tanning Beds? ☐ Yes ☐ No Frequency: __________

SKIN HISTORY QUESTIONNAIRE

Do you consider your skin to be: ☐ Normal ☐ Sensitive ☐ Dehydrated ☐ Dry ☐ Oily ☐ Blotchy ☐ Red
Check all that apply ☐ Other: ______

Do you feel you are affected by the following (check all that apply):

☐ Acne Scars ☐ Broken Capillaries ☐ Oversize Pores ☐ Scarring ☐ Stretch Marks/Striae
☐ Fine Lines ☐ Hypopigmentation ☐ Photoaging (Sun Damage) ☐ Skin Texture Issues ☐ Wrinkles
☐ Crepey Skin ☐ Hyperpigmentation ☐ Sagging Skin ☐ Skin Laxity (Looseness) ☐ Psoriasis
☐ Blackheads ☐ Acne ☐ Rosacea ☐ Dark Circles ☐ Melasma
☐ Cysts ☐ Eczema ☐ Patchy Dryness ☐ Milia ☐ Other: ______

Have you recently noticed a change in your skin tone, texture, or appearance? ☐ Yes ☐ No
If yes, please explain: ______

Have you experienced pigmentation changes (skin discoloration or light/dark patches? ☐ Yes ☐ No

If yes, when did the pigmentation onset (include age & duration):______

If yes, did pigmentation changes coincide with: ☐ Med Use ☐ Pregnancy ☐ Sun Exposure ☐ Other:______

Currently under physician's care for any skin problems? ☐ Yes ☐ No *Condition:*______

Do you have any other medical issues not listed above that may affect your skin? ☐ Yes ☐ No

If yes, please describe: ______

Do you regularly take (at least weekly): ☐ Aspirin ☐ Ibuprofen ☐ Fish Oil ☐ Blood Thinners ☐ Alcohol ☐ Vitamin E

Have you: **Had Collagen, Botox, or other Dermal Filler Injections in the past?** ☐ No ☐ Yes

If Yes: Last Treatment Date: ______ *Product Type/ Name:* ______

Ever used Accutane? ☐ Yes ☐ No **Receive Depilatories/Waxing:** ☐ Yes ☐ No **Have Permanent Makeup?** ☐ Yes ☐ No

Ever had skin cancer? ☐ Yes ☐ No **Use tanning beds?** ☐ Yes ☐ No **Use fake tanning products?** ☐ Yes ☐ No

Ever had facial surgery or suffered facial trauma? ☐ Yes ☐ No
*If yes, list date & type of surgery/trauma:*______

Recently had laser resurfacing? ☐ Yes ☐ No *If yes, list date & type of treatment:*______

Have you had any of the following in treatment area in the last 12 months? Check all that apply:
☐ Accutane/Isoretinoin ☐ Dermal Fillers ☐ Laser Hair Removal ☐ Permanent Makeup ☐ Waxing/Depillatory
☐ Botulinum Toxin ☐ Facial/Hydrafacial ☐ Laser Resurfacing ☐ Surgery
☐ Chemical Peel ☐ IPL Skin Treatment ☐ Microdermabrasion ☐ Tattoo(s)
Please specify treatment type & last treatment date here:______

______

What are your chief complaints about your skin and/or reasons for seeking Aesthetic or Facial Treatments?

______

______

I affirm the above information is accurate to the best of my knowledge and authorize the clinic staff to perform the requested and discussed services. I understand that the Clinic Staff are not responsible for any errors that may occur as a result of any omissions or incorrect information on this form.

______ ______ ______

Patient Name (Print) **Patient Signature** **Date**