



PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Today's Date: _____

Home Phone: _____ Business Phone: _____

Cell # or Preferred Contact #: _____ Emergency Contact: _____

How did you hear about us? _____

Describe the nature of your visit? _____

What are your expectations? _____

Medical History:

Do you have any serious health conditions? NO YES Describe: _____

Do you have any allergies? NO YES List all allergies: _____

Are you currently pregnant or planning a pregnancy? NO YES

Do you smoke? NO YES

Do you exercise? NO YES How often? _____

How much water do you drink daily? _____

List all medications you are currently taking (blood thinners, antibiotics, herbs, supplements, vitamins, aspirin etc.): _____

Are you currently under medical care for any reason? If yes, explain: _____

Have you waxed, used depilatories, bleaches or other chemical processes? NO YES Describe: _____

Have you had any chemical peels? NO YES Describe: _____
 Have you had laser/IPL treatments? NO YES Describe: _____
 Have you had Botox or Collagen injections in the past 6 months? NO YES Describe: _____

Skin:

Do you have a history of breakouts? NO YES
 If so, what is the frequency of your breakouts? Frequent Occasional Rarely
 Do you experience cystic breakouts? NO YES
 Do you have any scarring as a result from your acne? NO YES Describe: _____
 Have you ever been treated for acne? NO YES Describe: _____
 Have you had prolonged sun exposure (or tanning bed) in the past month? NO YES Describe: _____
 Are you using chemical tanning solutions? NO YES Describe: _____
 Do you use sunscreen on a regular base? NO YES Describe: _____
 Have you ever had skin cancer? NO YES Describe: _____
 Are you prone to cold sores? NO YES Describe: _____
 Do you develop keloid scars? NO YES Describe: _____
 Do you have history of any specific skin diseases? NO YES Describe: _____
 Have you experienced hyper-pigmentation? (Darkening of the skin) NO YES Describe: _____
 Have you experienced hypo-pigmentation? (Lightening of the skin) NO YES Describe: _____

Do you use topical ointments? Retin-A
 Glycolic
 Lactic Acid
 Salicylic
 Hydroquinone

Please circle ALL medical conditions and medications that you have now or have ever had in the past :

- Accutane
- Anticoagulants
- Gold Therapy
- Seizures
- HIV/ AIDS
- Cancer (of any kind)
- Irregular heartbeat
- Active bacterial, Viral, or Fungal Infections
- Herpes HSV 1 (cold sores)
- Herpes HSV 2 (genital)
- HPV (genital warts)

I certify that the above medical history information is accurate and correct:

Patient Signature: _____ Date: _____
 DR/Tech Signature: _____ Date: _____

FITZPATRICK SKIN TEST SKIN TYPE EVALUATION

SCORE	0	1	2	3	4	YOUR SCORE
YOUR NATURAL EYE COLOR?	LIGHT; BLUE, GRAY, GREEN	MEDIUM; BLUE, GRAY, GREEN	BLUE	DARK BROWN	BROWNISH BLACK	
NATURAL COLOR OF YOUR HAIR?	SANDY OR RED	BLOND	CHESTNU T OR DARK BLOND	DARK BROWN	BLACK	
COLOR OF YOUR NON-EXPOSED SKIN?	REDDISH	VERY PALE	PALE WITH BEIGE TINT	LIGHT BROWN	DARK BROWN	
DO YOU HAVE FRECKLES ON NON-EXPOSED AREAS?	MANY	SEVERAL	FEW	INCIDENTAL	NONE	

GENETIC DISPOSITION SCORE: _____

SCORE	0	1	2	3	4	YOUR SCORE
WHAT HAPPENS IF YOU STAY TOO LONG IN THE SUN?	PAINFUL REDDNESS, BLISTERING, PEELING	BLISTERING, FOLLOWED BY PEELING	BURNS, SOMETIMES FOLLOWED BY PEELING	RARELY BURNS	NEVER BURNS	
TO WHAT DEGREE DO YOU TURN BROWN?	HARDLY OR NOT AT ALL	LIGHT COLOR TAN	REASONABL E TAN	TAN VERY EASILY	TURN DARK BROWN QUICKLY	
DO YOU TURN BROWN AFTER SEVERAL HOURS OF SUN?	NEVER	SELDOM	SOMETIMES	OFTEN	ALWAYS	
HOW DOES YOUR FACE REACT TO THE SUN?	VERY SENSITIVE	SENSITIVE	NORMAL	VERY RESISTANT	NEVER HAD A PROBLEM	

SUN REACTION SCORE: _____

SCORE	0	1	2	3	4	YOUR SCORE
WHEN DID YOU LAST EXPOSE THE AREA TO BE TREATED TO THE SUN, TANNING BOOTH, CREAM OR TAN SPRAY?	MORE THAN 3 MONTHS AGO	2-3 MONTHS AGO	1-2 MONTHS AGO	LESS THAN 1 MONTH AGO	LESS THAN 2 WEEKS AGO	
DID YOU EXPOSE THE AREA TO BE TREATED TO THE SUN?	NEVER	HARDLY EVER	SOMETIMES	OFTEN	ALWAYS	

TANNING HABITS SCORE: _____

TOTAL: _____

IF YOUR TOTAL SCORE IS:	THEN YOUR FITZPATRICK SKIN TYPE IS:
0-7	I
8-16	II
17-24	III
25-30	IV
OVER 30	V-VI

