BETTER AESTHETICS MEDSPA HEALTH QUESTIONNAIRE

NAME: **AGE:**

COSMETIC EVALUATION **Check appropriate box below for areas of concern.**

Acne/Acne Scars **Wrinkles** **Uneven Pigmentation** **Skin Texture** **Skin Elasticity** **Redness/Rosacea** **Thin Lips**
Enlarged Pores **Excessive Hair Growth** **Hair Loss** **Face/Leg Veins** **Weight/Figure**

Have you ever had permanent makeup tattooed? Y N Location _____

FITZPATRICK SKIN TYPE **Circle the box that best describes you.**

1	**Always burns easily, never tans, very fair skin tone**
2	**Usually burns easily, tans with difficulty; fair skin tone**
3	**Burns moderately, tans gradually; fair to moderate skin tone**
4	**Rarely burns, always tans well; medium skin tone**
5	**Very rarely burns, tans very easily; olive or dark skin tone**
6	**Never burns, deeply pigmented; very dark skin tone**

ETHNIC BACKGROUND (BE SPECIFIC):

MEDICAL HISTORY **Check box for conditions you currently have or have had in the past.**

SKIN
- ❑ ABNORMAL MOLES
- ❑ ABNORMAL REACTION TO SUN
- ❑ ACCUTANE IN LAST 12 MONTHS
- ❑ INFLAMMATORY SKIN CONDITION
- ❑ KELOIDS/EXCESSIVE SCARRING
- ❑ DARK SPOTS AFTER SKIN INJURY

IMMUNE SYSTEM
- ❑ AIDS/HIV
- ❑ ALLERGIES _____
- ❑ AUTOIMMUNE DISEASE
- ❑ CANCER
- ❑ CHEMOTHERAPY/ RADIATION
- ❑ CORTICOSTEROID USE
- ❑ DIABETES
- ❑ HAY FEVER
- ❑ HERPES SIMPLEX/ COLD SORES
- ❑ IMMUNE DEFICIENCY
- ❑ LUPUS
- ❑ ORGAN TRANSPLANT

CARDIOVASCULAR/CIRCULATORY
- ❑ ANTICOAGULANT THERAPY (BLOOD THINNERS)
- ❑ BLEEDING DISORDERS
- ❑ BLOOD CLOTS
- ❑ BRUISE EASILY
- ❑ HEART DISEASE
- ❑ HIGH BLOOD PRESSURE
- ❑ HIGH CHOLESTEROL
- ❑ IMPLANTED MEDICAL DEVICES
- ❑ LEG ULCER
- ❑ LIVER DISEASE
- ❑ MULTIPLE HEART MEDICATIONS
- ❑ PHLEBITIS (INFLAMM. OF VEIN)
- ❑ REYNAUD SYNDROME

NEUROLOGICAL
- ❑ FAINTING OR DIZZY SPELLS
- ❑ SEIZURES/CONVULSIONS
- ❑ STROKE
- ❑ ALS
- ❑ MYASTHENIA GRAVIS
- ❑ MULTIPLE SCLEROSIS
- ❑ PARKINSON'S DISEASE

OTHER
- ❑ HEPATITIS
- ❑ HORMONE THERAPY
- ❑ KIDNEY DISEASE
- ❑ THYROID DISEASE

FEMALES
REGULAR MENSTRUAL PERIODS Y N
BIRTH CONTROL METHOD _____
B.C. PILL (BRAND) _____
MENOPAUSAL SYMPTOMS Y N
PREGNANT OR LACTATING Y N
TRYING TO CONCEIVE Y N

PLEASE LIST SIGNIFICANT FAMILY MEDICAL HISTORY:

SURGERIES & COSMETIC PROCEDURES **Indicate past surgeries and cosmetic procedures, including chemical peels, lasers, etc.**

YEAR	TYPE	YEAR	TYPE

MEDICATIONS	NAME	DOSE	FREQ.	NAME	DOSE	FREQ.
List all current medications, including herbal, vitamins, minerals, and supplements.						

DRUG ALLERGIES

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ Date _____