Date: _____/_____/_____

COMPREHENSIVE NON-SURGICAL HEALTH HISTORY

Name:_____
FIRST MIDDLE LAST

Date of Birth: _____/_____/_____ Age: _____

Ms. Mrs. Mr. Dr. Single Married Divorced Life Partner Widowed Separated

Reason for consultation:

_____

Local Address:

_____
STREET CITY STATE ZIP CODE

Alternate Address (If Applicable) / Same as above

_____
STREET CITY STATE ZIP CODE

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____
Cell Phone: (_____)_____-_____

E-mail*: _____

☐ *YES! Sign me up for periodic emails with information on new technology, in office events, and specials.*
**The email address you provide will NOT be shared with outside parties.*

Preferred method of contact: Home Phone Work Phone Cell Phone E-mail

Employer: _____ Occupation: _____

Husband / Wife / Partner Name:_____
FIRST LAST

Employer: _____ Occupation: _____

Work Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Parent (If Patient is a Minor):_____
FIRST LAST

Person to Contact in Case of an Emergency: _____
FIRST LAST

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Your referral source:_____

This is a summary of your medical history and will be kept in this office in a confidential manner. At the time of your consultation, photos may be taken for documentation, or, to show you, in simulation, how your treatment outcome might appear. These images will also be maintained in a confidential manner and will not be used for educational or promotional purposes. **With your written permission only, protected health information may be:**

- Forwarded to the surgery center should you have surgery with Dr. Kay, or
- Dr. Kay refers you to another practitioner

PERSONAL NON-SURGICAL HISTORY

This critical information will be used to develop a customized treatment plan for you.
Please provide the following information:

Areas of Concern (Face and/or Body) —

What conditions/problem areas would you like improvement in? *Please check all that apply.*

- ☐ Sun Damage
- ☐ Brown Spots/Uneven Skin Color
- ☐ Freckles
- ☐ Acne/Pimples
- ☐ Clogged Pores
- ☐ Blackhead/Whiteheads
- ☐ Scarring
- ☐ Hard Bumps Under Skin
- ☐ Rough Texture
- ☐ Excessive Oiliness
- ☐ Dry Patches
- ☐ Red Blush
- ☐ Skin Laxity
- ☐ Lip Lines
- ☐ Wrinkles
- ☐ Volume Loss
- ☐ Fat Reduction

Skin Condition — *Please check all that apply.*

What type of skin do you have?

☐ Dry ☐ Normal to Dry ☐ Normal ☐ Combination ☐ Oily

When exposed to the sun, do you — *Please circle one.*

Always Burn (I) Usually Burn (II) Sometimes Burn (III) Rarely Burn (IV) Very Rarely Burn (V) Never Burn (VI)

What is your ethnicity_____

Do you have any facial scarring? Yes No

If you checked "yes," please specify Location: _____ Type: _____ Age of Scar: _____

Have you had or are you planning to have any facial surgery? Yes No

What procedures are you interested in? *Please check all that apply.*

- ☐ Microdermabrasion Treatments
- ☐ Chemical Peels
- ☐ Photo Rejuvenation (Brown/Red Spots)
- ☐ Fractionated Laser Skin Resurfacing
- ☐ Laser Hair Removal
- ☐ Vein Therapy (Legs/Face)
- ☐ Non-Surgical Body Contouring
- ☐ Surgical Body Contouring
- ☐ Skin Tightening
- ☐ Botox
- ☐ Dermal Fillers
- ☐ Cosmetic Surgery

What skin procedures have you had in the past?

_____

What injectables have you had in the past?

_____

Have you been under the treatment of the following? ❑ Dermatologist ❑ Plastic Surgeon ❑ Esthetician

To the best of your ability, please list any products you are currently using in their appropriate categories:

Cleanser: _____

Sunscreen: _____

Moisturizer: _____

Toner: _____

Eye Cream: _____

Mask: _____

Scrub: _____

Serums: _____

Night Cream: _____

Astringent: _____

Antioxidants: _____

Hydroquinone/Skin Brighteners: _____

Medical Conditions —

Do you have any chronic skin or medical disorders? *Please check all that apply.*

- ☐ Psoriasis
- ☐ Seizures
- ☐ Diabetes
- ☐ Dermatitis
- ☐ Melanoma
- ☐ Fever Blisters
- ☐ Cancer
- ☐ Rosacea
- ☐ HIV
- ☐ Auto Immune
- ☐ Hepatitis
- ☐ Keloid Scars
- ☐ Other: _____ _____

Do you get cold sores? _____

Do you have any allergies/Sensitivities? *Please check/list all that apply.*

☐ Aspirin ☐ Eggs ☐ Retin A ☐ Fragrances ☐ Hydroquinone

Other: _____

Please list all medications/supplements you are currently taking:

_____

_____

_____

Do these medications make you sensitive to sunlight? Yes No

Are you using any of the following products? *Please check all that apply.*

- ☐ Accutane
- ☐ Oral Contraceptives
- ☐ Zovirax
- ☐ Tetracycline
- ☐ Antibiotics (Oral and/or Topical)
- ☐ Retin A—Strength: _____ Duration: _____

Personal Information —

Please circle your current level of stress: (*Low*) 1 2 3 4 5 6 7 8 9 10 (*High*)

Please circle your normal level of stress: (*Low*) 1 2 3 4 5 6 7 8 9 10 (*High*)

Do you exercise? Yes No If so, how often?_____

Approximate date of your most recent sun burn? _____

Do you smoke? Yes No If so, how often? _____

Are you pregnant? Yes No Are you trying to get pregnant? Yes No

Do you have any of the following? Pacemaker Metal Implant Contact Lenses Hearing Aid

Is there any other information you feel is relevant for your skin care specialist to know?

_____

_____

_____

_____

_____

_____

By signing below you agree to having filled out this form to the best of your knowledge.

Form completed by: Self Spouse Parent Legal Guardian

Signature: _____ Date: _____/_____/_____