

Conway CosMedic Patient Information & Medical History

Name: _____ Date of Birth: _____ Male or Female Date: _____

Address: _____ City, State, Zip _____

E-Mail: _____ May we contact you via e-mail? Y N

Cell Phone #: _____ Home Phone#: _____ May we contact you & leave messages via phone Y N

Emergency Contact: Name & relationship: _____ Phone #: _____

Medical & Skin History: please check if you currently have or have had the following:

- | | |
|---|--|
| <input type="checkbox"/> Herpes/Cold Sores/Fever Blisters | <input type="checkbox"/> Sensitive to Anesthetics |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Photosensitivity Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypersensitivity to Skin Products |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Keloid Scar Formation |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Retin A Treatment |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Accutane Treatment |
| <input type="checkbox"/> Irregular Menses | <input type="checkbox"/> Use of Acne Products/Drugs |
| <input type="checkbox"/> Menopause | <input type="checkbox"/> Laser Work of any Type |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Use of Photosensitizing Products |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Waxing |
| <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Electrolysis |
| <input type="checkbox"/> Skin Infections | <input type="checkbox"/> Autoimmune Disorder |
| <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Tanning over last 6 weeks |
| <input type="checkbox"/> Possibly Pregnant | <input type="checkbox"/> Wear contact Lenses |
| <input type="checkbox"/> Use of oral Birth Control | <input type="checkbox"/> History of MRSA (Staph infection) |

List any other Medical Conditions/Illnesses: _____

Please list the name of your primary care physician & any other physicians you see on a regular basis: _____
_____ Phone # _____
_____ Phone # _____
_____ Phone # _____

List all medications you are currently taking including Prescription, Over-the-counter, & herbal:

List Drug Allergies: _____

List Food & any other Allergies: _____

What is your average alcohol consumption? _____

Do you smoke? Y N If Yes, How many packs per day? _____ For how many years? _____

Have you smoked in the past? Y N If Yes, How many packs per day? _____ When did you quit? _____

What is your current daily at home skin care regimen? _____

When were you last exposed to the sun? _____

Do you use tanning booths? Y N If so, how often? _____ Last usage? _____

Are you planning a holiday in the sun? Y N If so, how soon? _____

Do you use self tanning lotions/creams/sprays? Y N If yes, last usage? _____

Have you ever had Skin resurfacing/rejuvenation? Y N

Have you ever had Chemical Peels? Y N

Have you ever had Botox? Y N Dermal Fillers? Y N

List any other esthetic procedures you have had: _____

Areas of interest for esthetic treatment: _____

Type of Treatment interested in: _____

How did you hear about us? I saw an advertisement in: _____

I was referred by: _____

Patient Signature: _____ Date: _____