

New Patient Information Form / Medical History

NAME: _____

TODAY'S DATE: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: HOME (_____) _____ - _____

CELL (_____) _____ - _____

WORK (_____) _____ - _____

..... PLEASE INDICATE THE BEST NUMBER TO REACH YOU DURING OUR OFFICE HOURS

EMAIL: _____

..... PLEASE CHECK IF YOU WANT TO RECEIVE OUR NEWSLETTER FOR THE LATEST NEWS
AND SPECIAL PROMOTIONS

May we leave a message to verify your appointment time? YES NO

May we send correspondence to your home address? YES NO

How did you hear about us?

Are you preparing for a big event? YES NO

..... DATE OF EVENT: _____

..... PLEASE DESCRIBE THE EVENT:

What best describes your skin type?

- NORMAL DRY OILY COMBINATION ACNE PRONE
 MELASMA ROSACEA ECZEMA PSORIASIS

What skin care product line are you currently using?

Please list skin care products you have had a reaction to:

Please list ALL of your current medications, including over the counter medications such as Aspirin, Ibuprofen, Alka-Seltzer; topical medications such as Retin-A, Differin, Tazorac; Herbal Supplements and Vitamins, such as Garlic, Vitamin E, Evening Primrose Oil, Fish Oil, etc.

Please list any allergies to medications, latex, foods, Nickel, etc.

Have you ever used Accutane? YES NO
DATE OF LAST DOSE: _____

Do you smoke or use tobacco products? YES NO

Do you drink alcohol? YES NO

Have you ever had or been diagnosed with any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> COLD SORES/FEVER BLISTERS | <input type="checkbox"/> STROKE | <input type="checkbox"/> BLOOD CLOTS IN THE LEGS OR LUNGS |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> EPILEPSY-CONVULSIONS OR SEIZURES | <input type="checkbox"/> SWELLING OF THE LEGS |
| <input type="checkbox"/> THYROID DISORDER | <input type="checkbox"/> BLEEDING TENDENCY OR EXCESSIVE BRUISING | <input type="checkbox"/> HIGH BLOOD PRESSURE OR OTHER HEART CONDITIONS |
| <input type="checkbox"/> POLYCYSTIC OVARIAN SYNDROME | <input type="checkbox"/> HEART VALVE OR JOINT REPLACEMENT | <input type="checkbox"/> PACEMAKER OR IMPLANTED DEFIBRILLATOR |
| <input type="checkbox"/> ORGAN TRANSPLANTATION | | <input type="checkbox"/> EXCESSIVE SCARING OR KELOID (HYPERTROPHIC) SCARS |
| <input type="checkbox"/> CANCER | | <input type="checkbox"/> HIV OR AIDS |
| <input type="checkbox"/> DISEASES OF THE NEUROMUSCULAR JUNCTION (MYASTHENIA GRAVIS, LAMBERT-EATON SYNDROME, MUSCULAR DYSTROPHY, MULTIPLE SCLEROSIS, ETC.) | | |

Please list any medical conditions you have not listed above and any past surgeries

Are you currently pregnant or nursing? YES NO

Do you require prophylactic antibiotics before dental procedures? YES NO

Have you tanned or applied sunless tanning lotion in the last 30 days? YES NO

Which of the following best describes your skin type?

- ALWAYS BURNS, NEVER TANS ALWAYS BURNS, SOMETIMES TANS SOMETIMES BURNS, ALWAYS TANS
- RARELY BURNS, ALWAYS TANS BROWN, MODERATELY PIGMENTED SKIN BLACK SKIN

Do you have:

- HYPER-PIGMENTATION (DARKENING OF THE SKIN) HYPO-PIGMENTATION (WHITE AREAS ON THE SKIN)
- RAISED SCARS AFTER PHYSICAL TRAUMA, CUTS, INSECT BITES, ETC?

Please discuss your aesthetic concerns or any additional information you would like us to know

For laser hair removal only: Have you ever had laser hair removal? YES NO

Have you used any of the following hair removal methods in the past six weeks:

- NONE OF THE BELOW
- SHAVING WAXING ELECTROLYSIS PLUCKING TWEEZING
- STRINGING OR THREADING DEPILATORIES

I certify that the above statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update them if I have any changes in my health status.

SIGNATURE: _____ TODAY'S DATE: _____

My initials acknowledge the Skin Spa @ Newman Dermatology's 24-hour cancellation policy. A \$35 fee will be accessed for all appointments not given this courtesy.

INITIALS: _____