rejuvanalysis™

PATIENT MEDICAL/SKIN QUESTIONNAIRE

(Patient label here) Date: DD/MM/YY

Emergency contact name and number: _____

How did you hear about our clinic?

Friend/family member	☐	If so, who can we thank? _____
Community advertisement	☐	
Magazine advertisement	☐	
Google	☐	
Realself	☐	
Rate MDs	☐	
Other	☐	Please Explain: _____

MEDICAL HISTORY

Regarding your skin, are you currently under the care of a physician or dermatologist?

Yes ☐ No ☐

If Yes, for what condition(s)?

_____

_____

Do you have any of the following autoimmune disorders?

Lupus	☐	
Crohn's disease	☐	
Colitis	☐	
Rheumatoid arthritis	☐	
Connective tissue disease	☐	
Other	☐	Please Explain: _____

Other general (skin-related and non skin-related) medical conditions:

_____

_____

Are you currently on immunosuppressive or chemotherapy medications?

Yes ☐ No ☐

If on chemotherapy medications, when was your last treatment? _____

Please list all other medications and supplements/vitamins (including blood thinners, oral contraceptives, and those you may take either before or after a dental procedure:

_____

_____

Any recent changes to your form of contraception?

Yes ☐ No ☐

Have you had any dental procedures within the last 2 weeks or plan to in the next 2 weeks?

Yes ☐ No ☐

Do you take a daily baby aspirin?

Yes ☐ No ☐

When was the last time you took Advil, ibuprofen, Motrin or Toradol? _____

Have you ever used the following medications:

Accutane	Yes ☐	No ☐
Retin-A (Retinol, Differin, Tazorac, Renova, Tretinoin)	Yes ☐	No ☐
Benzoyl Peroxide	Yes ☐	No ☐
Steroids	Yes ☐	No ☐
Effudex/Aldara	Yes ☐	No ☐
Salicylic Acid	Yes ☐	No ☐
Glycolic Acid	Yes ☐	No ☐
Prescription acne medications	Yes ☐	No ☐

Do you have any allergies to medications?

Yes ☐ No ☐

If Yes, please list:

_____

Are you currently pregnant, trying to become pregnant or breastfeeding?

Yes ☐ No ☐

Do you have any active infections?

Yes ☐ No ☐

Do you get cold sores?

Yes ☐ No ☐

SURGICAL/PROCEDURAL HISTORY

Have you ever had surgery on your face or neck (including surgical treatment for skin cancer)?

Yes ☐ No ☐

If Yes, please list surgical procedures:

_____

_____

LIFESTYLE

What is your occupation?

_____

How would you describe your typical level of stress?

Minimal ☐
Slight ☐
Moderate ☐
Excessive ☐
Severe ☐
Critical ☐

How many glasses of water do you typically drink daily? _____

Do you smoke?

Yes ☐ No ☐

How often are you in the sun?

Rarely ☐
Sometimes ☐
Often ☐
Always ☐

To what extent to you use a tanning bed?

Never □
Rarely □
Sometimes □
Often □

Have you recently used a sunless tanner product or had a spray tan?

Yes □ No □

Do you burn:

Always □
Usually □
Sometimes □
Rarely □
Very rarely □
Never □

SKINCARE/SKIN TREATMENT HISTORY

What is your skin type?

Dry □
Oily □
Combination □
Acne prone □
Sensitive □
Rosacea □

What does your current skin care regime entail?

AM □/ PM □	Face wash	□	Product(s)	_____
AM □/ PM □	Toner/astringent	□	Product(s)	_____
AM □/ PM □	Anti-oxidant/serum	□	Product(s)	_____
AM □/ PM □	Moisturizer	□	Product(s)	_____
AM □	Sunscreen	□	Product(s)	_____
AM □/ PM □	Other product(s)	□	Product(s)	_____

Please indicate your current skin care concerns

Fine lines/wrinkles	□	Hypopigmentation	□
Brownspots/sundamage	□	Broken capillaries/veins	□
Oily skin/acne	□	Skin laxity/tissue descent	□
Dry skin	□	Acne scars	□
Skin dullness	□	Redness (rosacea)	□
Other concerns	□	Please list: _____	

Please outline the services and procedures that you think you may be interested in

Professional skin care products	☐
Glominerals mineral makeup	☐
Facials	☐
Chemical peels	☐
Botulinum toxin (ie. Botox/Xeomin)	☐
Dermal fillers	☐
Laser for texture, pigmentation or redness	☐
Surgical correction of facial aging	☐
Hand rejuvenation	☐
Laser hair removal	☐
Acne scars	☐
Belkyra (chin fat reduction)	☐
Lattise (eyelash lengthening)	☐
Not sure, open to suggestions	☐
Non-invasive fat reduction (Coolsculpting)	☐
Other(s):	☐ _____

Have you previously had experience with:

Botulinum toxin (ie., Botox)	Yes ☐	No ☐
Dermal fillers	Yes ☐	No ☐
Chemical peels	Yes ☐	No ☐
Laser procedures	Yes ☐	No ☐

Other comments:

_____

_____

_____

_____

THANK YOU for taking the time to fill this form out. The information provided is important for determining medical and cosmetic needs and the provision of treatment. If there are any changes to your medial history, including medications, it is very important that they are reported to our office staff as soon as possible.