HARTSOUGH DERMATOLOGY

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Phone (815) 226-9642 Fax (815) 226-9672

ame: _____

Address: _____

Phone #1: _____ **Phone #2:** _____

Female ☐ **Male** ☐ **Age:** _____ **Referred by:** _____

Reason for consultation

- ☐ Acne
- ☐ Brown spots or sun damage
- ☐ Enlarged blood vessels
- ☐ Fine lines or wrinkles
- ☐ Flushing of the skin
- ☐ Skin laxity
- ☐ Skin texture or scars
- ☐ Unwanted hair

Questions about skin

1. How long have you been concerned about this area(s)? _____
2. At what age did you notice this concern(s)? _____
3. Are your present skin concern(s) getting more pronounced? ☐ Yes ☐ No
4. Have you ever been treated for this concern(s)? ☐ Yes ☐ No
   If yes, when? _____
   What method? _____
5. Are you currently taking medication for your skin's concern(s)? ☐ Yes ☐ No
   If yes, what is it? _____
6. What topical skin medications or products are you currently taking?
   ☐ Retin-A® ☐ Hydroquinone or bleaching agent ☐ Other _____
7. Have you ever had laser / IPL hair removal? ☐ Yes ☐ No
8. Have you ever used the following hair removal methods in the past 6 weeks?
   ☐ shaving ☐ waxing ☐ electrolysis ☐ plucking/tweezing ☐ stringing ☐ depilatories
9. Have you ever had skin resurfacing or rejuvenation or chemical peels? ☐ Yes ☐ No
10. Have you ever had treatments for pigmented lesions? ☐ Yes ☐ No
11. Do you form thick or raised scars (keloids) from cut or burns? ☐ Yes ☐ No
12. Do you experience hyperpigmentation (redness) from burns, cuts, insect bites? ☐ Yes ☐ No
13. Have you had cold sores or fever blisters? ☐ Yes ☐ No

Skin Type choices (when exposed to the sun for about 1 hour with no protection):

- Always burns, never tans ☐
- Always burns, sometimes tans ☐
- Sometimes burns, always tans ☐
- Rarely, burns, always tans ☐
- Brown, moderately pigmented skin ☐
- Black skin ☐

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1. When were you last exposed to the sun or tanning booth? _____
2. Do you use self tanners? ☐ Yes ☐ No
3. Are you planning a vacation in the sun? ☐ Yes ☐ No

Personal history:

1. Do you smoke? ☐ Yes ☐ No if yes _____ packs per day
2. What is your daily consumption of alcohol? _____
3. Do you wear contact lenses? ☐ Yes ☐ No

Medical history:

1. Are you currently under the care of a physician? ☐ Yes ☐ No. If yes, for what:

_____

2. Do you have any of the following?

☐ Arthritis	☐ Epilepsy or seizures	☐ HIV / Aids
☐ Any active infection	☐ Heart disease	☐ Sensitive teeth
☐ Bleeding disorders	☐ Hepatitis	☐ Skin cancer or moles
☐ Bruising	☐ Herpes simplex	☐ Skin injury
☐ Dark spots of pregnancy	☐ High blood pressure	☐ Vision deficits
☐ Diabetes	☐ Hormone imbalance	☐ Other_____

3. Do you have allergies to any of the following? (check all that apply) ☐ medications ☐ latex

☐ food ☐ plants ☐ anesthesia ☐ other_____

4. Do you take any of the following?

☐ Accutane	☐ Appetite depressants	☐ Insulin
☐ Antibiotics	☐ Aspirin or Ibuprofen	☐ Sedatives
☐ Anti-coagulants	☐ Cortisone or steroids	☐ Thyroid medication
☐ Anti-depressants	☐ Hormone/contraceptives	☐ Other____

5. Are you taking herbal preparations or vitamins? (St. John's Wort, Vitamin E) ☐ Yes ☐ No

_____

For female patients:

1. Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

I have answered the questions contained in this questionnaire to the best of my knowledge. I understand that it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this information as it occurs.

Signature: _____ **Date:** _____