MEDICAL HISTORY (please print)

LAST NAME_____ FIRST NAME_____DOB _____ M ❒ F ❒

Welcome!
Our goal as your Woodlands Wellness and Cosmetic team, is to deliver the absolute best, professional wellness and cosmetic experience possible. To customize your experience and assure your satisfaction and safety, please complete the questions below.

WHAT ARE YOUR PRIMARY CONCERNS FOR TODAY'S VISIT?

MEDICATIONS

Please list all the medications you are currently taking, including strength and number of times per day taken. ☐ **NONE**

_____

_____

MEDICAL HISTORY

Please mark any of the following diagnoses that apply to you, please include the year you were diagnosed. ☐ **NONE**

☐ Acid Reflux	☐ Coronary Artery Disease	☐ Migraine Headaches
☐ Allergic Rhinitis	☐ Depression	☐ Osteoarthritis
☐ Anxiety	☐ Diabetes	☐ Pacemaker
☐ Asthma	☐ Emphysema	☐ Seizure Disorder
☐ Atrial Fibrillation	☐ Gout	☐ Thyroid Disease
☐ Attention Deficit	☐ Hepatitis	☐ Neuromuscular Disorder
☐ Cancer (Breast, Ovary, Uterine)	☐ High Blood Pressure	
☐ Cancer (Lung)	☐ High Cholesterol	
☐ Cancer (Prostate)	☐ HIV/AIDS	
☐ Congestive Heart Failure	☐ Irritable Bowel Syndrome	

DRUG ALLERGIES

If you are allergic to any medications, please write the name of the medication and the adverse effect. ☐ **NONE**

☐ Anesthetics	☐ Aspirin	☐ Codeine	☐ Latex	☐ Penicillin	☐ Sulfa
☐ Other :					

Reaction:_____

_____

SURGICAL HISTORY

Please mark any of the following surgeries that apply to you and note the year performed. ☐ **NONE**

☐ Appendix	☐ Heart Bypass	☐ Tonsillectomy
☐ Artery Bypass	☐ Hysterectomy	☐ Osteoarthritis
☐ Balloon Angioplasty	☐ Knee Surgery	☐ Tubal Ligation
☐ Cardiac stent	☐ Mastectomy	☐ Seizure Disorder
☐ Colon Surgery	☐ Organ Transplant	☐ Valve Replacement
☐ Disc Surgery	☐ PE Tubes	☐ Vasectomy
☐ Facial Surgery	☐ Prostate Surgery	☐ Breast Implants
☐ Gallbladder	☐ Splenectomy	☐ Liposuction

FAMILY HISTORY

Please mark the disease and circle the family member who has had this disease.
(F= Father, M= Mother, B= Brother, S= Sister, GP= Grandparent) ☐ **NONE**

☐ Breast Cancer M S GP	☐ Heart Disease F M B/S GP	☐ Adopted
☐ Colon Cancer F M B/S GP	☐ Melanoma F M B/S GP	☐ Unknown
☐ Diabetes F M B/S GP	☐ Prostate Cancer F B GP	

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Occupation:_____

Name of Spouse:_____

Names/Ages of Children:_____

Exercise times per week:_____Nicotine: ☐ **No** ☐ **Yes** (packs/day)_____Alcohol: ☐ **No** ☐ **Yes** (drinks per day)_____

HEALTH HISTORY

Do you have a living will? ☐ **No** ☐ **Yes** Date last reviewed _____

When was your last complete physical? _____

When was your last Tetanus booster? _____

Have you received a pneumonia vaccine? ☐ **No** ☐ **Yes** Date of vaccine_____

MEN AND WOMEN OVER AGE 50

When did you last have:
A stool specimen tested for blood/cancer? ☐ **Never** ☐ **Yes** _____
A colonoscopy or sigmoidoscopy to check for colon cancer? ☐ **Never** ☐ **Yes** _____
An exercise stress test? ☐ **Never** ☐ **Yes** _____
An EKG? ☐ **Never** ☐ **Yes** _____

FOR MEN OVER 50

When was your last PSA blood test? ☐ **Never** ☐ **Yes** _____

FOR WOMEN ONLY

Are you pregnant? ☐ **No** ☐ **Yes** If yes, how far along?_____
When was your last mammogram? ☐ **Never** ☐ **Yes** _____ At which facility?_____
When was your last pap smear? ☐ **Never** ☐ **Yes** _____ Performed by: _____
When was your last bone density scan? ☐ **Never** ☐ **Yes** _____
When was the first day of your last menstrual period?_____
What form of contraception do you currently use? ☐ **None** ☐ **Yes** _____

PREFERRED PHARMACY

Name _____

Address _____

Phone _____

COSMETIC HEALTH QUESTIONS

☐ **YES** ☐ **NO** Have you ever had herpes, cold sores, fever blisters, keloids or hives? Please circle each you've had.
☐ **YES** ☐ **NO** Is your family prone to vascular blemishes? If yes, please indicate type below:
☐ Spider Veins ☐ Varicose leg veins ☐ Cherry Angioma ☐ Facial Capillaries ☐ Rosacea ☐ Other_____
☐ **YES** ☐ **NO** Have you ever visited a dermatologist, plastic surgeon, cosmetic dentist, or other skin care clinic? Please list_____
☐ **YES** ☐ **NO** Do you suntan? When was your most recent sun exposure?_____
☐ **YES** ☐ **NO** Do you use sunscreen?
☐ **YES** ☐ **NO** Do you use any artificial tanning products?
☐ **YES** ☐ **NO** Have you ever been on Accutane? Date of last treatment? _____
☐ **YES** ☐ **NO** Are you currently taking or have you recently finished taking any antibiotics?_____
☐ **YES** ☐ **NO** Have you ever suffered a severe allergic reaction? If so, explain._____
_____
☐ **YES** ☐ **NO** Have you ever had an allergic reaction to local or topical anesthesia? If so, explain.
_____
☐ **YES** ☐ **NO** Do you have any skin conditions? If so, which?_____
☐ **YES** ☐ **NO** Do you have a history of atypical moles, melanoma, or skin cancer in your family? Please list:
_____
☐ **YES** ☐ **NO** Are you currently undergoing chemotherapy or radiation?_____

Describe your skin: ☐ Dry ☐ Oily ☐ Normal ☐ Combination

Are you currently using any form of: ☐ Retin-A ☐ Differin ☐ Tazorac ☐ Glycolic Acid ☐ Salicyic Acid
☐ Hydroquinone ☐ Other:_____

PLEASE INDICATE THE FOLLOWING CONCERNS: ☐ **NONE**

☐ Acne	☐ Lip Lines	☐ Hair Reduction
☐ Enlarged Pores	☐ Lip Volume Loss	☐ Erectile Disfunction
☐ Brown Spots	☐ Nose-to-Mouth Lines	☐ Urinary Incontinence
☐ Fine Lines/Wrinkles	☐ Red Spots/Flushing	☐ Vaginal Dryness
☐ Facial Dryness	☐ Scarring	☐ Loss of Libido
☐ Facial Oiliness	☐ Skin Texture	☐ Thinning Brows
☐ Facial Volume Loss	☐ Hair Loss	☐ Hormones
☐ Forehead	☐ Under Eye Circles/Crepiness	☐ Weight Loss
☐ Lines/Frown Lines	☐ Uneven Skin Texture	☐ Neck and Chest Discoloration
☐ Other_____ _	☐ Other_____ _	☐ Other_____ _

Please describe adverse reactions to topical skin care products, makeup, medications or cosmetic treatments: ☐ **NONE**

_____

_____

Do you feel your current skin care regimen is addressing your primary concerns listed today? ☐ **Yes** ☐ **No**
If no, please explain:

_____

_____

PLEASE INDICATE WHICH OF THE FOLLOWING TREATMENTS YOU HAVE RECEIVED: ☐ **NONE**

☐ Rhytidectomy (Face lift) Date	☐ Dermal Fillers Date
☐ Rhinoplasty (Nose) Date	☐ Botox Injections Date
☐ Blepharoplasty (Eye lift) Date	☐ Breast Augmentation Date
☐ Laser Resurfacing Date	☐ Breast Reduction Date
☐ Medical Acid Peels Date	☐ Liposuction Date
☐ Collagen Injections Date	☐ Tummy Tuck Date
☐ Other	☐ Other

ADDITIONAL COMMENTS FOR YOUR PROVIDER _____

_____

_____

Patient Signature_____Date _____

Provider_____Date_____

Name: _____ Date: _____

Skin Type Classification Questionnaire

Score		0	1	2	3	4
	What is the natural color of your hair?	Sandy Red	Blonde	Chestnut, dark blonde	Dark brown	Black
	What is your eye color?	Light blue, Gray, Green	Blue, Gray, Green	Hazel	Dark brown	Brownish black
	What is the color of unexposed skin?	Reddish	Very pale	Pale with Beige Tint	Light brown	Dark brown
	How many freckles are on unexposed skin?	Several	Many	Some	Few	None
	What happens when you are in the sun TOO long without sunblock?	Painful redness, blistering, peeling	Burning followed by peeling	Burning followed by tanning	Rarely burns	Never burns
	How well do you turn brown?	Never	Some light color tan	Reasonable tan	Easily tan	Always tan
	Do you turn brown within one day of sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very Sensitive	Sensitive	Normal	Little sensitivity	No sensitivity
	When did you last expose yourself to the sun or artificial sun treatments?	More than 3 months ago	2-3 Months ago	1-2 Months ago	Less than 1 month ago	Less than two weeks ago
	Do you normally expose the area to be treated to the sun?	Never	Seldom	Sometimes	Often	Always
	TOTAL					

Genetic Orientation (Please Choose):

____African American ____Asian ____ Caucasian ____Hispanic
____ Mediterranean ____Native American ____Other

00-07 Points = Skin Type I
08-16 Points = Skin Type 2
17-25 Points = Skin Type 3
26-30 Points = Skin Type 4
31-40 Points = Skin Type 5 & 6

PATIENT CONSENT FORM

Consent for the taking and publication of photographs, videotape, and/or Computer Images

I, _____, hereby consent that photographs, videotape, and/or computer imaging may be taken of me or of parts of my body under the following conditions:

☐ Pre-treatment and post-treatment photographs will be taken of my treatment for medical record purposes. The photographs will be taken by my physician or staff member of my physician. I understand that these photographs will be the property of the attending physician and *Woodlands Wellness & Cosmetic Center*.

☐ Pre-treatment and post-treatment photographs will be taken of my treatment for medical record purposes. Such photographs and/or videotape shall be used only for medical records, teaching, publication, marketing, or scientific research by my physician and *Woodlands Wellness & Cosmetic Center***,** provided that in any such publication the use of my name and identity is kept confidential and protected. Such photographs may be edited at the discretion of my physician to protect my confidentiality or emphasize the treated area.

☐ I have had the opportunity to discuss this consent with my attending physician or a qualified staff member of *Woodlands Wellness & Cosmetic Center*. I agree that all of my questions have been answered. I hereby waive all rights I might have to such photographs, videotape, and computer images and do hereby release, discharge, and save harmless my physician & *Woodlands Wellness & Cosmetic Center* and their respective managers & employees from all such claims and liabilities whatsoever in law and in equity arising from the use of such photographs, videotape and computer images described above.

☐ I have **declined** having any photos taken by my attending physician or any staff of ***Woodlands Wellness & Cosmetic Center.*** By signing below, I am indicating that I understand that I will be unable to visualize the treatment changes over time.

I have read and fully understand this Photo/Video/Computer Imaging Consent and agree to all of its terms.

Patient Signature _____ Date _____

Witness Signature _____ Date _____