PATIENT DEMAGRAPHICS

Name _____ **Date:** _____/_____/_____
Last Middle (Initial) First

Address _____ **DOB:** _____/_____/_____ **Age** _____

City _____ **State** _____ **Zip** _____

Home phone (_____) _____-_____ **Business/Cell phone** (_____) _____-_____

Email Address _____ **Text Messages? Yes / No**

MEDICAL RECORD

1. Do you follow a special diet? Yes / No **If yes, Explain** _____

2. Are you pregnant? Yes / No **Are you on birth control? Yes / No**

3. Do you get cold sores? Yes / No **Are you on preventative therapy? Yes / No** **What Type?** _____

4. Any menopause problems? Yes / No **Hormones? Yes / No**

5. Are you: Claustrophobic? Yes / No **Epileptic? Yes / No**

Diabetic? Yes / No **Arthritic? Yes / No**

6. Do you have heart problems? Yes / No **If yes, Explain**_____

7. Do you smoke? Yes / No

8. Do you wear contact lenses? Yes / No

9. Do you feel nervous tension? Yes / No

10. Any skin problems? Yes / No **If yes. Explain**_____

11. Sinus Headaches? Yes / No **Any implants? Yes / No**

12. Are you allergic to any fruits, vegetables, nuts, metals, etc.? Yes / No

If yes, Explain _____

13. History of any skin cancer? Yes / No

If yes, Explain _____

14. Have you had recent surgery? Yes / No **If yes, Explain** _____

15. Are you taking any medication? Yes / No **If yes, List:**_____

_____

16. Do you use RetinA? Yes / No **Reason / How often?** _____

17. What changes would you like to see in your skin? _____

18. How did you hear about us? _____

Additional Information: _____

MedSpa Day Spa
& RANDALL DERMATOLOGY