KESPRA MEDICAL CENTER

22 Meridian Rd, Suite 10 Edison, NJ 08820

Patient History Questionnaire

Patient Name: ____________ Date: ____________ D.O.B. ____________
Address: ____________ City: ____________ State: ____________ Zip: ____________
Home Phone: ____________ Cell Phone: ____________ E-Mail: ____________
Occupation: ____________ Employer: ____________ Wk. Phone: ____________
Person to contact in case of emergency: ____________
Reason for consultation: ____________
Are you currently under a physicians care? ____________ Specify: ____________

HAVE YOU EVER HAD OR BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

	Yes	No		Yes	No		Yes	No
Heart Murmur	( )	( )	Do you smoke	( )	( )	Corneal Abrasions	( )	( )
Blepharoplasty	( )	( )	Circulatory problems	( )	( )	Phlebitis	( )	( )
Faint/Dizzy spells	( )	( )	Do you wear contacts	( )	( )	Skin Cancer	( )	( )
Keloids	( )	( )	Hyperpigmentation	( )	( )	Allergies	( )	( )
Thyroid Disease	( )	( )	High Blood Pressure	( )	( )	Diabetes	( )	( )
Herpes Simplex	( )	( )	Bleeding Disorder	( )	( )	Hepatitis	( )	( )
Tumors/Growths	( )	( )	Chemotherapy/Radiation	( )	( )	Asthma	( )	( )

List all medications you are currently taking:
List any drug, makeup, food, or skin allergies:
Have you been on Accutane in the past 9 months Laser resurfacing in the past year
Are you using, or have you ever used Retin-A Last application
Are you pregnant If pregnant, how far along are you
Have you ever been tested for HIV Results
Do you have an immune disorder that would impair your healing process
Are you prone to genital herpes breakouts Cold Sores
Do you have any Venereal Diseases If so, what are they
What is your natural haircolor Eye color
Have you recently undergone a skin peel If so, how long ago
Is your skin condition normal or abnormal
When did you last tan your skin Sun, tanning beds, creams
Have you ever had sclerotherapy If so, how long ago
When a scar appears on your skin, is it significantly dark in color
Are you currently taking birth control pills
Are you taking oral or injectable steroids If so, for what condition
Please circle your skin type: Oily Normal Dry Sensitive Combination
In your own words, describe your skin
What about your skin are you hoping to improve
Going back three generations, what is your family ancestry

Fitzpatrick Skin Test

Please circle the one that best describes your skin type:

Type I: Always burns, never tans. Red or blonde hair, light eyes.

Type II: Somewhat tans, mostly burns.

Type III: Sometimes burns, mostly tans, also known as olive complexion.

Type IV: Rarely burns, almost always tans, also known as olive complexion.

Type V: Moderately pigmented (Indian, Hispanic.)

Type VI: African American

MAJOR ALLERGIES:

	Yes	No		Yes	No
Milk	( )	( )	Papaya	( )	( )
Sugar/Beets	( )	( )	Apples	( )	( )
Retinoic acid	( )	( )	Pineapples	( )	( )
Aspirin	( )	( )	Citrus Fruits	( )	( )

PREVIOUS COSMETIC TREATMENTS:

	Yes	No		Yes	No
Acid Peel	( )	( )	Face Lift	( )	( )
Laser Surgery	( )	( )	Botox	( )	( )
Collagen	( )	( )	Microdermabrasion	( )	( )

Patient signature: ____________ Date: ____________

KESPRA MEDICAL CENTER

22 Meridian Rd, Suite 10 Edison, NJ 08820

NAME ______________________ DATE ______________
ADDRESS ______________ CITY ______________ STATE ________ ZIP ________
HOME PHONE ______________ E-MAIL ______________________
CELL PHONE ______________ WORK PHONE ____________ D.O.B. ____________
HOW DID YOU HEAR ABOUT US ______________ REFERRED BY ______________

Have you ever had any of the following conditions?
Check all that apply

- ________ AIDS
- ________ Anemia
- ________ Arthritis Latex/Other:
- ________ Auto Immune Deficiency
- ________ Asthma
- ________ Blood Transfusion
- ________ Chemotherapy (active)
- ________ Diabetes
- ________ Dizziness
- ________ Epilepsy
- ________ Fainting
- ________ Hay Fever
- ________ Heart Disease
- ________ Hepatitis
- ________ High Blood Pressure
- ________ Infection (active)
- ________ Kidney Disease
- ________ Liver Disease
- ________ Lupus
- ________ Melanoma
- ________ Mental Disorder
- ________ Nervous Disorder
- ________ Radiation Treatment
- ________ Respiratory Problems
- ________ Skin Conditions
- ________ Sinus Problems
- ________ Stomach Problems
- ________ Stroke
- ________ Thyroid Problems
- ________ Tuberculosis
- ________ Ulcers
- ________ Venereal Disease
- ________ Other:

Allergies:
Cosmetics: ______________________
Latex/Other: ______________________

Have you ever/are you currently using:

Any retinoic acid product (Retin-A, Renova)	YES	NO
Prescription Acne	YES	NO
Birth Control Pills/Patch	YES	NO
Steroids	YES	NO
Are you pregnant?	YES	NO
Due Date: ____________		
Are you lactating?	YES	NO

Previous Cosmetic Facial

Acid Peel	YES	NO	Date: ________
Botox	YES	NO	Date: ________
Collagen	YES	NO	Date: ________
Tattoo/Perm make-up	YES	NO	Date: ________
Waxing	YES	NO	Date: ________
Facial Surgery	YES	NO	Date: ________
Laser Surgery	YES	NO	Date: ________
Microdermabrasion	YES	NO	Date: ________

Have you ever had:

Cold Sore	YES	NO	
Fever Blister	YES	NO	
Frequency:	<1/yr	1-3/yr	4+/yr

List all current medications/supplements that you take:
____
____
____

List any questions you have:
____
____

EVALUATION:

Skin Type: ________ Normal ________ Oily ________ Dry ________ Combination ________ Other

Conditions: ________ Texture ________ Sun Damage ________ Acne/Oily
________ Pigment Problems ________ Sensitive Skin Other: ______________

Sunburn Sensitivity: ________ Always ________ Usually ________ Occasionally ________ Rarely ________ Never

Area of concern: ______________________