



Health History

Any information obtained in this questionnaire is strictly confidential and will remain in your permanent record.

Name: _____ Date of Birth: _____
Name you would like to be called: _____ Date of last physical exam: _____
Address: _____
City: _____ State: _____ Zip: _____
Employer: _____
Female _____ Male _____ Marital Status S M D W
Phone number you prefer to be reached at: _____
Email Address: _____
How did you hear about Chicago Skin Solutions? _____
Emergency Contact Name: _____ Phone Number: () _____

Please answer the following questions about yourself:

What is your natural hair color? _____ What is your natural eye color? _____
When in the sun do you: _____ Burn Easily _____ Tan Easily _____ Turn a little red
Do you use a self-tanner? If yes, last time used? _____ Are you planning a vacation in the sun? If yes, when? _____
Do you use tanning salons? If yes, last time used? _____
Have you ever had cosmetic procedures, invasive or non-invasive? _____ Please list what and which products: _____
Have you ever had any laser or IPL treatments? _____ Yes _____ No If yes, what kind? _____ Reactions: _____
Are you allergic to: _____ Milk _____ Apples _____ Citrus _____ Aloe Vera _____ Aspirin _____
_____ Hydroquinone
Have you ever had a reaction to any products? _____ Yes _____ No If yes, please explain: _____
Do you consider your skin to be sensitive? _____ Yes _____ No Resilient? _____ Yes _____ No
To help us determine what treatments would or would not be appropriate for your skin type, please state your heritage: _____

Check all that apply:

- _____ Herpes Simplex virus _____ Insomnia _____ Polycystic Ovary Disease
_____ Acne _____ Lupus _____ Keloid scarring
_____ Rosacea _____ Lymph Edema _____ Stroke
_____ Couperose (broken capillaries) _____ Nail Disorders _____ Thyroid Disease
_____ Arthritis _____ Phlebitis _____ Fainting Spells
_____ Asthma _____ Pregnancy _____ Chemical Peels
_____ Cancer _____ Psoriasis _____ Permanent make up
_____ Claustrophobia _____ Seborrhea _____ Trying to become pregnant
_____ Depression _____ Scleroderma _____ Smoker
_____ Eczema _____ Sensitivities _____ Breastfeeding
_____ Epilepsy / Seizure Disorder _____ Weight Gain _____ Nerve Damage
_____ Heart Condition _____ Chest Pain _____ Hypertension
_____ HIV _____ Circulation Problems
_____ Hyper/Hypo Pigmentation _____ Diabetes

Check all that apply:

- _____ Accutane _____ Antibiotics _____ Birth Control _____ Hormone Replacement
_____ Contact Lenses _____ Blood Thinner _____ Pace Maker _____ Exfoliants
_____ Renova _____ Metal Plates or Pins _____ Retin-A/Glycolic/AHA's _____ Aspirin / NSAIDs
_____ Hydroquinone _____ Benzoyl Peroxide

Current Medications: List any medications and over-the-counter drugs you are currently taking:

List any surgeries or hospitalizations:

Table with 3 columns: Year, Reason, Hospital

List any medications or supplements you may be allergic to or have an adverse reaction:

Patient Signature: _____ Date: _____
Witness: _____ Date: _____