HONET
DERMATOLOGY | COSMETIC

Name: ____ Date: ______________________
First   Last

Birth date: ____/_______/______

Address: ____

City: _______________________________ State: ___________ Zipcode: _________________

Cell Phone: ______________________ Home Phone: __________________________

Email (Optional): ______________________________ Occupation: _______________________

How did you hear about us? ____

What brings you to Honet Cosmetic? ____

Ethnic Background: ____

Medical History

Do you have any chronic medical conditions which we should know about? Yes No

If so, please list: ____

Do you have any allergies to latex, medications, herbal, or natural supplements? Yes No

If so, please list: ____

Do you have, or have you had, any changes in medical history recently? Yes No

Please list any and all current/past surgeries or surgical procedures

____

____

Have you taken Accutane within the past year? Yes No

Are you on any anticoagulants, daily Aspirin, Motrin, Aleve or Advil? Yes No

Are you a smoker? Yes No

Do you have veneers on your teeth? Yes No

Do you have a history of cold sores, fever blisters or herpes 1 or 2? Yes No

If so, when was your last outbreak? ____________________________ (The use of Lasers, IPL, and Silkpeel can trigger an outbreak and pretreatment with antiviral medication is necessary)

Do you have a history of hypo/hyper-pigmentation? Yes No

Do you have a history of keloid scarring? Yes No

Do you have a history of lupus or autoimmune disease? Yes No

If so, please list:____

Have you ever been treated with a laser, microdermabrasion, or chemical peel? Yes No

If so, please list: ______________________________

What skin care products are you currently using? ______________________________

____

____

Are you happy with your skin care products? Yes No

Do you or have you used any topical medications or creams such as Retin-A, Renova, Tazorac, Differin, Obagi or any others? Yes No

If so, please list: ______________________________

Do you have any permanent makeup or tattoos? Yes No

If so, please list: ______________________________

WOMEN ONLY:

Are you or could you be pregnant? Yes No

Are you currently breast-feeding? Yes No

Are your menstrual cycles normal? Yes No

Please tell us about your skin (Check all that apply)

□ Normal	□ Acne	□ Hyper-pigmentation
□ Dry	□ Large Pores	□ Hypo-pigmentation
□ Oily	□ Melasma	□ Broken Capillaries

Natural Hair Color: ______________________ Eye Color: ______________________

Have you had any recent sun exposure in the past 4-6 weeks, including tanning beds, bronzing creams or spray-on tans? Yes No

If so, please specify: ______________________________

What are your skincare goals? ______________________________

____

Additional information you would like your technician to know: ______________________________

____

Patient Signature: ______________________________ Date: ____________________

Witness: ______________________________ Date: ____________________

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