Affinity Wellness 4 Life
4335 Solutions Lane
Bradenton, FL 34211
941-739-7900

Personal Medical History

Patient Name: _____ Date: _____

Address: _____ City: _____

St: _____ Zip: _____Home Phone: _____ *Cell:_____

***Email: _____ DOB:_____**

Emergency Contact: _____ Phone: _____

***How did you hear about us? _____**

What did you want to consult about today?

- ☐ **Brown Spots**
- ☐ **Wrinkles**
- ☐ **Red/Flushed Skin**
- ☐ **Large Pores**
- ☐ **Acne**
- ☐ **Scars**
- ☐ **Distended Blood Vessels (res spots that may be spidery in appearance)**
- ☐ **Other: _____**

How many years have you noticed this problem? _____

Have you received prior treatment for this problem? Yes _____ No _____
If yes, when? _____
By what method? _____

Are your present skin problems getting more pronounced? Yes _____ No_____

Are you currently taking medication for your skin problem? Yes _____ No _____

Skin Typing

Skin Quality

- ☐ **Dry Skin**
- ☐ **Normal Skin**
- ☐ **Oily Skin**
- ☐ **Oily T-Zone**

Skin Sensitivity:

- ☐ **Normal – not Sensitive**
- ☐ **Sensitive**
- ☐ **Very Sensitive**

Skin Breakouts:

- ☐ **Acne**
- ☐ **Acne Rosacea**
- ☐ **Occasional Pimples**
- ☐ **Breakouts During Menstrual Cycle**

Please mark your skin type (when exposed to sun <u>without sunscreen</u> for 1 hour)

- ☐ **I- Always Burn, never tans**
- ☐ **II- Always burn, sometimes tan**
- ☐ **III- Sometimes burn, sometimes tan**
- ☐ **IV- Always tans**
- ☐ **V- Hispanic, Asian, Mediterranean, Middle Eastern**
- ☐ **VI- Black**

History of Skin

Are you, or have you been treated for acne with any of the following:

- ☐ **Topical Vitamin A e.g. Retin A**
- ☐ **Benzoyl Peroxide**
- ☐ **Azelaic Acid**
- ☐ **Salicylic Acid**
- ☐ **Alpha Hydroxy Acids**
- ☐ **Oral antibiotics**
- ☐ **Other (please specify): _____**

Are you prone to any of the following?

- ☐ **Keloid Scarring**
- ☐ **Atopy or Eczema**

If so, is it localized or extensive? _____

- ☐ **Skin Injury**
- ☐ **Skin Cancer**
- ☐ **Others Please Explain _____**

Have you ever had any of the following?

- ☐ **Facial Surgical Procedures**
- ☐ **Laser Treatments**
- ☐ **Laser Hair Removal**
- ☐ **Dermabrasions**
- ☐ **Moles or sun spots removes**
- ☐ **Waxing**
- ☐ **Chemical Peels (please specify) _____**
- ☐ **Other skin treatments (please specify) _____**

_____

General Health

Are you or do you have any of the following?

- ☐ **On a Diet**
- ☐ **Pregnant**
- ☐ **Diabetic**
- ☐ **Porphyria**
- ☐ **Smoker**
- ☐ **Lactating**
- ☐ **Epileptic**
- ☐ **Facial Implant/Excess filling**
- ☐ **Pacemaker/Cardiac Irregularities**

Do you have any history of the following?

- ☐ **Septicemia**
- ☐ **Herpes Sores**
- ☐ **Bruise Easily**
- ☐ **Skin Injury**
- ☐ **Skin Cancer**
- ☐ **Heart Disease**
- ☐ **Diabetes**
- ☐ **Bleeding Disorders**
- ☐ **Autoimmune Disease**
- ☐ **History of Anaphylaxis**
- ☐ **Hives**
- ☐ **Myasthenia Gravis**
- ☐ **ALS**

Do you have any allergies, especially skin related? Yes _____ No _____
If yes, please explain: _____

Medication allergies? Yes _____ No _____
If yes, please explain: _____

Are you currently taking any of the following medications?

- ☐ **Aspirin**
- ☐ **Hormones/Birth Control**
- ☐ **Anti-coagulants**
- ☐ **Thyroid Medication**
- ☐ **Other (please specify): _____**
- ☐ **Insulin**
- ☐ **Prednisone**
- ☐ **Sedatives**

Are you taking any herbal supplements/vitamins (ie St John's Wort) Yes___ No___
If yes, please specify: _____

Alcohol Consumption? Yes _____ No ____
If yes, how much? _____

Do you smoke? Yes _____ No ____

When were last exposed to the sun (including tanning bed) _____

Do you sunscreen daily? Yes _____ No ____

Are you planning a holiday in the sun? Yes ____ No ____

History of Products Used

What skin care products are you using or have used in the past?

_____
_____

***All sales are FINAL. No transfers, exchanges or misuse of any product or services rendered other than the original patient of whom they are intended for.** (Initial) **_____**

PATIENT SIGNATURE: _____
DATE: _____

Physician/Provider:_____