Hulten Enterprises

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 treatment _____ Yes _____ No If yes, what kind? Reactions:

Are you allergic t _____ Milk _____ Apples _____ Citrus _____ Aloe Vera _____ Aspirin _____
_____ Hydroquinone

Have you ever had a reaction to any products _____ Yes _____ No 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 to you:

_____ 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	_____ Menopause
_____ Hyper/Hypo Pigmentation	_____ Diabetes	

Check all that apply:

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

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

List any recent surgeries or hospitalizations:

Year	Reason	Hospital

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

Patient Signature:_____ Date:_____

Witness:_____ Date:_____

Hulten Enterprises

Personalized Treatment

Check all items that are of concern for you:

☐	Fine lines and wrinkles	☐	Loss of collagen
☐	Major lines around nose and mouth area	☐	Large pores
☐	Rough texture of skin	☐	Spider veins
☐	Tired looking skin	☐	Excessive sweating
☐	Unwanted hair	☐	Age spots or sun damaged skin
☐	Uneven skin tone	☐	Rosacea
☐	Acne	☐	Sagging or loose skin
☐	Freckles	☐	Oily skin
☐	Dryness	☐	Hyperpigmentation/Melasma

Ranking of Concerns:
1
2
3
4
5

What products are you using:
_____ Cleanser
_____ Toner
_____ Eye Cream
_____ Moisturizer
_____ SPF

Recommended Treatments

Treatment Type	Number of Treatments	Frequency	Cost
Microdermabrasion			
Facial			
BOTOX ® Cosmetic			
Dermal Filler			
Laser Hair Removal			
Skincare Products			
Chemical Peels			
Photofacial			
Thermage Skin Tightening			
NIR Skin Tightening			
Laser Leg Vein			
Fractional Resurfacing			

Notes and Comments