Patient History Questionnaire

Name: ____Date: _____________________________________

Address: ____City: _______________State: __________Zip: _____________

Home Phone: _____________________ E-Mail: ____

Cell Phone: ____________________Work Phone: __________________Date of Birth: _____________________________

How did you hear about us? __________________________________Referred by: _____________________________

Reason for your visit? ____

List all medications/supplements you are currently taking: ____

Allergies: ____

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

❑ Venereal Disease	❑ Anemia	❑ Arthritis	❑ Auto Immune Deficiency
❑ Asthma	❑ Blood Transfusion	❑ Diabetes	❑ Chemotherapy (active)
❑ Dizziness	❑ Epilepsy	❑ Fainting	❑ Hay Fever
❑ Heart Disease	❑ Hepatitis Type_______	❑ Lupus	❑ High Blood Pressure
❑ Kidney Disease	❑ Infection (active)	❑ Stroke	❑ Mental Disorder
❑ Melanoma	❑ Tuberculosis	❑ Ulcers	❑ Respiratory Problems
❑ Radiation Treatment	❑ Sinus Problems	❑ AIDS	❑ Other: _________
❑ Thyroid Problems		❑ Liver Disease	

Have you ever or are you currently using:

Circle One

Retin-A, Renova, Retin-A Micro	Yes	No	If Yes, which one(s)?_____________
Antibiotics	Yes	No	If Yes, which one(s)?_____________
Birth Control	Yes	No	If Yes, which one(s)?_____________
Drugs	Yes	No	If Yes, which one(s)?_____________
Steroids	Yes	No	If Yes, which one(s)?_____________

Have you ever had:

Circle One

Cold Sore/Fever Blister Yes No

If Yes, how frequently? _________

Circle One

Are you pregnant? Yes No

Are you nursing? Yes No

Previous Cosmetic Procedures (Check all that apply):

❑ Chemical Peel	❑ Botox	❑ Collagen	❑ Tattoo/Perm makeup
❑ Hair Removal	❑ Facial Plastic Surgery	❑ Microdermabrasion	❑ Other:_____________

Circle or Check

Skin Type:	❑ Normal	❑ Oily	❑ Combination	❑ Dry	❑ Sensitive
Skin Condition:	❑ Rough Texture	❑ Sun Damage	❑ Acne	❑ Uneven color/pigmentation	❑ Large pores
Areas of Concern:	❑ Oily/Acne	❑ Aging	❑ Dry Skin	❑ Uneven tone	❑ Maintenance/ Prevention

Skin Regimen (Specify products you are currently using):

Cleanser ____________________ Exfoliant ____________________ Treatment ____________________ Hydration ____________________

Sun Sensitivity (Circle one):

Extremely Sensitive   Somewhat Sensitive   Slightly Sensitive   Not Sensitive

Patient Signature: _________________________________ Date: _________________________________

Hanami MEDSPA

Patient Assessment

Patient Name: ______________________________ DOB:______________ Date: __________

Current Medications: ____

Allergies
Medications: ____

Aspirin YES/NO   Strawberries YES/NO   Milk YES/NO   Sugar YES/NO

Past Medical History: Check all that apply

Diabetes: ____ Hypertension: ____ Eczema: ____ Psoriasis: ____ Cancer: ____ Obesity: ____
Irregular menstrual periods: ____ Excess hair growth: ____ Keloids or large scar formations: ____
Asthma: ____ Impetigo: ____ AIDS/HIV: ____ Heart Disease: ____ Skin Cancer: ____ Lupus: ____
Bleeding history: ____ Other Health Problems: ___________________________

Tobacco Smoker: YES/NO **QTY/Frequency**: _______ **Alcohol Use**: YES/NO **QTY/Frequency:** _______
Do you use illicit drugs: YES/NO **QTY/Frequency:** _______ **Are you pregnant:** YES/NO
Planning for pregnancy: YES/NO **Sun-tan/use tanning booth:** YES/NO **History of cold sore**: YES/NO
Have you ever been on Accutane or Isotretinoin? YES/NO **If YES when?** ______________________

Acne History: Age of onset: __________

Family History of acne:

	Age of onset	Severity	Treatment
Mother			
Father			
Siblings			

Previous or present acne treatments (both OTC and prescriptions)

Product	Response	Currently Using	
________	________	☐ Y	☐ N
________	________	☐ Y	☐ N
________	________	☐ Y	☐ N
________	________	☐ Y	☐ N

Previous or present skincare products

Product	Response	Currently Using	
________	________	☐ Y	☐ N
________	________	☐ Y	☐ N
________	________	☐ Y	☐ N
________	________	☐ Y	☐ N

Type of makeup used: ____

Patient assessment of clinical severity

Severity (circle): none=1 mild=2 moderate=3 severe=4
Co=comedones Pa=papules Pu=pustules Cy=cysts

Location								
Face	1	2	3	4	Co	Pa	Pu	Cy
Forehead	1	2	3	4	Co	Pa	Pu	Cy
Back	1	2	3	4	Co	Pa	Pu	Cy
Chest	1	2	3	4	Co	Pa	Pu	Cy
Other (________)	1	2	3	4	Co	Pa	Pu	Cy

Acne precipitation factors
- ☐ Sports
- ☐ Meds or topical creams
- ☐ Self excoriation (picking)
- ☐ Stress
- ☐ Diet
- ☐ Menstrual

Staff Signature: ______________________________________ Date: ________________