

# OCULUS SKIN CARE CENTRE

## SKIN HEALTH HISTORY

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ GENDER: M F  
LAST FIRST

ADDRESS \_\_\_\_\_ PHONE (H) \_\_\_\_\_  
 \_\_\_\_\_ PHONE (W / C) \_\_\_\_\_  
CITY STATE ZIP CODE

EMAIL \_\_\_\_\_ REFERRED BY \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_  
NAME RELATION PHONE NUMBER

### HEALTH HISTORY

1. Are you currently under a physicians care?  Yes  No
2. Have you undergone any surgery within the last year?  Yes  No  
 If yes, please give a brief description \_\_\_\_\_
3. Please check any past or present conditions.
 

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Rosacea
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hormone Imbalance	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Auto-immune Disease
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Neuro-muscular Disease	<input type="checkbox"/> Lupus
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Slow Wound Healing	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Herpes / Cold Sores/Fever Blisters
4. List any medications, vitamins, OTC's and/or herbal remedies you take regularly: \_\_\_\_\_
5. **Are you allergic to any medications?**  **Yes**  **No**  **Not Sure**  
 If yes, please specify. \_\_\_\_\_
6. Do you have any other allergies?  Yes  No  Not Sure  
 If yes, please specify. \_\_\_\_\_
7. Do you smoke?  Yes  No  Occasionally  Quit
8. Do you exercise?  Yes  No  Occasionally
9. Do you get regular sleep?  Yes  No  
 If no, please explain. \_\_\_\_\_
10. **Are you currently wearing contacts?**  **Yes**  **No**

### WOMEN ONLY

11. Are you currently taking oral contraception?  Yes  No
12. Are you pregnant or trying?  Yes  No
13. Are you nursing?  Yes  No

### ABOUT YOUR SKIN

14. **Are you on or have you ever been prescribed Accutane?**  **Yes**  **No** **If yes, when?** \_\_\_\_\_
15. Are you currently using prescription Retin-A, Avita, Differin, Tri-Luma or Tretinoin cream or gel?  Yes  No
16. Have you ever been diagnosed with Rosacea, Eczema, Dermatitis, etc.?  Yes  No
17. Have you ever had a chemical peel? (TCA, Blue, Phenol, Jessner)  Yes  No
18. Are you experiencing any of the following conditions? (Please check all that apply)
 

<input type="checkbox"/> Ingrown Hairs	<input type="checkbox"/> Oily Skin	<input type="checkbox"/> Regular Breakouts	<input type="checkbox"/> Fine lines
<input type="checkbox"/> Facial Reddening	<input type="checkbox"/> Dryness	<input type="checkbox"/> Broken Capillaries	<input type="checkbox"/> Brown Spots
19. Please list any other concerns or conditions regarding your skin: \_\_\_\_\_
20. What is your current skin care regimen? (Please check all that apply)
 

<input type="checkbox"/> Cleanser	<input type="checkbox"/> Toner	<input type="checkbox"/> Moisturizer	<input type="checkbox"/> Topical Vitamins
<input type="checkbox"/> Eye Cream	<input type="checkbox"/> Scrub	<input type="checkbox"/> Home Peel	<input type="checkbox"/> Glycolic Acid
<input type="checkbox"/> Mask	<input type="checkbox"/> Sun Protection SPF# _____	<input type="checkbox"/> Other _____	

### TREATMENTS OF INTEREST (Please check all that apply)

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Men's Treatments  | <input type="checkbox"/> Body Treatments | <input type="checkbox"/> Facial Waxing  |
| <input type="checkbox"/> Lash/Brow Dye     | <input type="checkbox"/> Acne Treatments   | <input type="checkbox"/> Anti-Aging      | <input type="checkbox"/> Chemical Peels |
| <input type="checkbox"/> Rosacea Therapy   | <input type="checkbox"/> Professional guidance concerning home treatment and regimen |  |   |

Have you or are you considering Cosmetic Surgery, Permanent Makeup and/or Non-Surgical Cosmetic Procedures?  
 Yes  No **If yes, please specify.** \_\_\_\_\_

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**SKIN HEALTH HISTORY**

I confirm that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment. I understand that it is my responsibility to give a 24-Hour advanced notice when rescheduling or canceling an appointment. I understand that OCULUS Skin Care Centre reserves the right to charge me 50% of my scheduled service if I do not give a 24-hour advanced notice when canceling or rescheduling my appointment.

I consent to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publications or sales purposes. No photographs revealing my identity will be used without my written consent. If my identity is not revealed, these photographs may be used and displayed publicly without my permission.

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**SIGNATURE**

**DATE**    /    /