MEDICAL HISTORY **Date__________________**

Name____Age________

Date of birth: _____________ Email: ____

Address____

City______________________________________State_________Zip________________

Home Phone__________________________Work or CellPhone _____________________

Preference number for contact (appointment reminders or other)____________________

Primary Physician's Name and Number____

Please list all medications you are currently taking: _________________________________

____

List vitamin supplements you are on: ____

List any medication or skin allergies (with reactions):

____

Allergy to latex or neoprene?____

Allergy to shellfish or other food?____

With an "x", mark any of the following illnesses you have or have ever had in the past:

____Multiple Severe Allergies/Hypersensitivity to medications

____ Do you carry an EpiPen for severe allergic reactions?

____Sensitivity/Allergy to Lidocaine

____Autoimmune Disease

____History of Cold Sores

____Allergy to Beef

____ Myesthenia Gravis

____ Multiple Sclerosis

----____ Amyotrophic Lateral Sclerosis (ALS)

____ Muscle Weakness

Medical History (continued)

With an "x", mark any of the following illnesses you have or have ever had in the past:

____Autoimmune Disease
____Acne
____Depression
____Skin Disease
____High Blood Pressure
____Cold Sores
____Diabetes
____ Lambert-Eaton Syndrome
____ Parkinson's Disease
____Neurological Disorders
____Vision Problems
____Hepatitis
____Cancer
____ History of taking Gold orally

List any OTHER MEDICAL CONDITIONS not listed above that you currently have or have had in past:
____
____

Previous Hospitalizations/Operations: ____

____

Have you had Plastic Surgery or other surgery to your face/neck areas & when?
____

WOMEN: Are you Pregnant, Trying to get Pregnant, or Lactating (nursing)?_________

Do you have regular periods? ____________PMS or heavy bleeding?_________

Are you going thru menopause? _________________________

During pregnancy, did you ever get hyperpigmentaion or masking/melasma? _____

Do You Smoke? ____How often? ______Live w/ smoker? _____

Do you drink Alcohol? ____ How often? _________

Do you wear Contact Lenses? ________

Do you exercise? _____ How often? ______

Any history of fatigue, loss/reduction of libido, depression, irregular bowel movements/constipation or any other physical symptom/changes that you want Dr Silkey to know about:

____

____

Any history of skin conditions or current concerns? (Ex: rosacea, cancer, itching, psorasis, new lump or bump, etc....)

____

What skin care line(s) are you currently using? ____________________________

Sunscreen _______________ Eye Cream ____________________

Moisturizer__________________ Night Repair Cream_____________

Are you happy with your skin care line/routine?___________________________

Are you using or have you used in past (and when)?

____Alpha/Beta Hydroxy Acids ____Retinol ____Renova

____Retin-A ____Accutane ____Hydroquinone

Please rate how you feel about the overall quality of your skin:

1(bad) ……..to 10 (fantastic!) ______

What do YOU feel is your skin type? (We will obviously assess you as well)

Normal_______ Acne prone___________Dry__________Sensitive________

Combination (list where dry and where oily)___________________________

In order of importance, beginning with #1, make a wish list of what you would like to see improved in your skin in the next 30 days……

_____Reduction in wrinkles _____Reduction of brown spots/sun damage

_____Reduction of acne _____Acne scars diminished

_____Reduction of spider veins

_____Hair reduction

_____Weight Reduction

_____Improved appearance of excess fat

_____Improved Facial Volume

_____ "Double chin" reduction

If you had a "magic wand" and could change things about you skin/hair or anything in your overall health what would be your top 3 choices be?

1 ____

2 ____

3 ____

Please mark with an “x” all treatments/services that interest you:

_____Laser (Photofacial, hair removal, sun damage)

_____Professional Skin Care Program

_____Peel Skin Treatments

_____Leg Veins

_____Tattoo Removal

____Botox/Dysport/Xeomin

____Ultherapy (skin lifting/tightening)

____Dermal Filler (to add volume back)

____Laser skin tightening

____Scar Treatment

How did you hear about us? Website, friend, internet search, etc...

____

If friend or other referral:

Whom may we thank for referring you to us? ______________________________

Happy patients and clients are the *cornerstone* of Dr Silkeys philosophy and practice. We send $50 gift certificates to the referring person for telling people about us! We will leave the certificate anonymous unless you want us to use your name.

Refer people to us and you will receive your $50 gift certificate to use on any service or products available.

Please give us suggestions on how we can improve our services and treatments. Your thoughts and ideas are VERY important to us and Dr Silkey reads EACH and EVERY one of the comments card herself!! This can be left anonymous or you can use your name if you want Dr Silkey to know who it came from.

If there is a certain products or services you would like to see us provide, please let us know! Dr. Silkey is always researching new professional products and looking at ingredients closely to offer the best but safest choices available.

I certify that I have answered the questions to the best of my ability and will notify SilkeySkinMD immediately for any pertinent changes in my medical conditions.

______________________________ **(Your signature)** ______________ **(Date)**

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