Forget Me Not
HEALTHCARE CLINIC

SKIN CARE HISTORY

Patient Name: _____

Address: _____
_____
_____

Date of Birth: _____ Telephone Number _____

What Conditions/problem areas would you like improved: Circle Any!

Sun Damage		Brown Spots/Uneven Sk		Dry Patches		Clogged Pores	
Acne/Pimples		Unwanted Hair		Scarring		Wrinkles	
Dermatitis		Excessive Oiliness		Blackheads		Whiteheads	
Rosacea		Upper lip lines		Freckles			

Other: _____

Medications: [List all you are taking, the dosage (strength), and how often you take it.]

1. _____ 4 _____
2. _____ 5 _____
3. _____ 6 _____

Drug Allergies: _____

What conditions/problem areas would you like improved?

_____

How much time do you spend in the sun? _____. Do you use Tanning Beds? _____

Do you wear sunscreen? ___ How often? _____ SPF/Brand: _____

How would you describe your skin? _____

In the sun, do you: Always burn ◯ Sometimes burn ◯ Never burn ◯ Always tan ◯

Bad reaction to cosmetics: _____

Are you pregnant? _____ Are you breastfeeding? _____

Amount of water you drink a day _____ 8oz glasses

Nicotine Use? _____ Alcohol use? If so, how much? _____

Check ALL Medications that apply:

☐ bHcg (beta HCG)	☐ Acutane	☐ Steroids	☐ Vitamin E
☐ Birth Control	☐ NSAIDs/ Aspirin	☐ Thyroid	☐ Herbals
☐ Testosterone	☐ DHEA	☐ Chemotherapy	☐ Acne Medication
☐ Minoxidil	☐ Blood Thinners	☐ Antidepressants	
☐ Rentin-A Renova			

Previous Cosmetic Facial Treatments, Surgery, Resurfacing, or Laser Treatments:

☐ Acid Peels	Date:	☐ Waxing.	Date:
☐ Botox	Date:	☐ Facial Plastic Surgery	Date:
☐ Dermal Fillers	Date:	☐ Laser Surgery	Date:
☐ Tattoo/Perm Makeup	Date	☐ Microdermabrasion	Date:

Pre-Treatment Medical History	Yes	No	Describe
Any allergic reaction to botulinum toxin?	○	○	
Any history of swallowing problems?	○	○	
Any history of asthma or emphysema?	○	○	
Any history of a slow heart rate or rhythm?	○	○	
Any history of neuromuscular disease?	○	○	
Are you allergic to albumin (eggs)?	○	○	
Are you allergic to lidocaine?	○	○	
Are you allergic to gram positive bacteria proteins?	○	○	
Do you have a bleeding disorder?	○	○	
Any history of anaphylactic reaction?	○	○	
Have you ever had a cold sore/fever blister?	○	○	Frequency < 1yr ○ Frequency 1-3/year. ○ Frequency >4 year. ○
Do you have a current/active infection?	○	○	
Laser Surgery in the past 14 days?	○	○	
Chemical peel in the past 14 days?	○	○	

I have answered the above questions truthfully and will notify you of any changes in medications and physical conditions.

Patient Signature:_____ Date: _____