INNOVATIONS
SKIN REJUVENATION & LASER CENTER

PATIENT HEALTH HISTORY

NAME (FIRST & LAST)	/ / DATE OF BIRTH	M / F GENDER	/ / TODAY'S DATE

EMAIL

MOBILE	HOME	YES / NO MAY WE LEAVE A DETAILED MESSAGE?	SS#
ADDRESS	CITY	STATE	ZIP
EMERGENCY CONTACT (FIRST & LAST NAME)		PHONE	
LEGAL GUARDIAN NAME (if applicable)	ADDRESS	PHONE	D.O.B.
PRIMARY CARE PROVIDER	PHONE	CARDIOLOGIST	PHONE
HOW DID YOU HEAR ABOUT US?		OCCUPATION	

PLEASE SPECIFY YOUR ETHNICITY:

☐ AFRICAN AMERICAN ☐ ASIAN ☐ CAUCASIAN ☐ HISPANIC ☐ MEDITERRANEAN ☐ NATIVE AMERICAN ☐ OTHER

MEDICAL HISTORY: Please check all that apply

- ☐ Acne
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Cancer
- ☐ Cold sores/fever blisters
- ☐ Cardiac conditions
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness/fainting spells
- ☐ Drug/alcohol addiction
- ☐ Eating disorders
- ☐ Endocrine disorders
- ☐ Eczema
- ☐ Epilepsy/seizures
- ☐ Heart disease
- ☐ Hemorrhoids
- ☐ Herpes
- ☐ Hepatitis
- ☐ Hernia(s)
- ☐ Herpes
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Hormone Replacement Rx
- ☐ Implants
- ☐ Irregular heartbeat
- ☐ Kidney disease
- ☐ Keloid scars
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Lupus
- ☐ Pacemaker
- ☐ Polycystic ovary disease
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Seizures
- ☐ Shingles
- ☐ Skin cancer
- ☐ Radiation/chemo
- ☐ Thyroid conditions
- ☐ Transplants
- ☐ Vitiligo
- ☐ Other:
- ☐ Other:

FEMALES:

ARE YOU PREGNANT? .... ☐ YES ☐ NO
ARE YOU CURRENTLY BREASTFEEDING? .... ☐ YES ☐ NO
ARE YOU PLANNING TO BECOME PREGNANT? .... ☐ YES ☐ NO
DID YOU DEVELOP HYPERPIGMENTATION OR MELASMA DURING PREGNANCY? .... ☐ YES ☐ NO
DO YOU HAVE REGULAR PERIODS? .... ☐ YES ☐ NO
HAVE YOU OR ARE YOU GOING THROUGH MENOPAUSE? .... ☐ YES ☐ NO

TOBACCO USAGE

☐ NEVER ☐ FORMER ☐ CURRENT

If a smoker, number of packs per day: _______________ Total years of smoking: _______________ Tobacco Type: _______________

ALCOHOL USAGE

☐ NO ALCOHOL Drinks per day: ☐ Less than 1 ☐ 1-2 ☐ 3-4

MEDICATIONS List all medication names and dosages including creams, over the counter, and herbal supplements.

☐ NO CURRENT MEDICATIONS ____________________

PAST SURGERIES

☐ NONE **OR** LIST ALL PAST SURGERIES: ____________________

ALLERGIES / ALERTS Select all that apply.

☐ NONE	☐ Latex Allergy	☐ Penicillin Allergy	☐ Problems with scarring / wound healing
☐ Lidocaine Allergy	☐ Contact lenses	☐ History of tanning beds	☐ Autoimmune disorders
☐ Irregular scarring	☐ Blood Thinners	☐ Easy bleeding/Hemophilia	☐ Sensitivity to makeup

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Are you currently being treated for any medical condition(s)? . . . . **YES** **NO**
   If YES, please explain:
2. Have you ever seen a physician regarding your skin? . . . . **YES** **NO**
   If YES, please explain:
3. Are you allergic to topical antibiotic products or numbing desensitizers? . . . . **YES** **NO**
   (e.g. Polysporin, Bacitracin, Neosporin or 'Caine' family of drugs)
4. Have you had any aspirin or blood thinning medication in the past 72 hours? . . . . **YES** **NO**
   If YES, please explain:
5. Have you / are you currently using medications such as Accutane? . . . . **YES** **NO**
   Date of last use:
6. Are you currently using Retin-A, retinol, tretinoin, Tazorac, Differin gel or hydroquinone? . . . . **YES** **NO**
   Concentration ___________ %
7. Are you currently using Alpha Hydroxy Acids (AHA's) incl. glycolic or lactic acid home care products? . . . . **YES** **NO**
8. Are you currently using any other skin care products? . . . . **YES** **NO**
   Please list:
9. Do you sunbathe? . . . . **YES** **NO**
   If yes, when was your last exposure?
10. Are you currently using or have you used a tanning bed or sunless tanner? . . . . **YES** **NO**
    If yes, when was your last exposure / use?
11. Are you prone to keloid scarring? . . . . **YES** **NO**
12. Please state if you've previously had any of the following and date of last treatment: . . . .
    Laser treatment:
    Chemical peel:
    Microneedling:
    Botox / neurotoxins:
    Cosmetic filler:
    Microblading:

PLEASE INDICATE WHICH OF THE FOLLOWING CONCERNS YOU HAVE ABOUT YOUR SKIN:

- ☐ Aged skin
- ☐ Enlarged pores
- ☐ Blackheads
- ☐ Volume loss
- ☐ Uneven skin color
- ☐ Acne
- ☐ Fine lines / wrinkles
- ☐ Age spots
- ☐ Sun damage
- ☐ Dry skin
- ☐ Redness
- ☐ Melasma
- ☐ Skin texture
- ☐ Oily skin
- ☐ Other

PLEASE INDICATE WHICH SERVICE(S) YOU ARE INTERESTED IN OR WOULD LIKE MORE INFORMATION ON:

- ☐ Laser skin rejuvenation
- ☐ Microblading
- ☐ Acne treatment
- ☐ PRP
- ☐ Microneedling
- ☐ Filler injections
- ☐ Facial
- ☐ Sun damage repair
- ☐ Botox
- ☐ Anti-aging treatment
- ☐ Dermaplaning
- ☐ Chemical peel

I CONFIRM THAT THE ANSWERS TO THE ABOVE QUESTIONNAIRE ARE TRUE AND CORRECT.

Patient Signature **Date**

Legal Guardian Signature (if applicable) **Date**

Medical Professional Signature **Date**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT *

I, ______________________________, have been given the opportunity to read a copy of Innovation's Skin Rejuvenation's "Notice of Privacy Practices."

Please Print Name

Signature **Date**

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (please check all that apply)

HOME TELEPHONE: ___________________________

- ☐ OK to leave message with detailed information.
- ☐ Leave message with call-back number only.
- ☐ OK to give information to family member or other person (please specify person's name below).

WORK TELEPHONE: ___________________________

- ☐ OK to leave message with detailed information.
- ☐ Leave message with call-back number only.
- ☐ OK to give information to family member or other person (please specify person's name below).

WRITTEN COMMUNICATION

- ☐ OK to mail to my home address
- ☐ OK to mail to my work / office
- ☐ **I agree to permit discussions with my employer or benefits personnel.**

I authorize the following individuals to discuss my medical care if necessary.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

THIS INFORMATION WILL BE CONSIDERED CURRENT AND VALID UNLESS OTHERWISE NOTIFIED.

Please Print Name Signature Date

*** FOR OFFICE USE ONLY ***

We attempted to obtain written acknowledgement of receipt of our "Notice of Privacy Practices," but acknowledgement could not be obtained because:

______ Individual refused to sign
______ Communication barriers prohibited obtaining the acknowledgement
______ An emergency situation prevented us from obtaining the acknowledgement
______ Other (please specify): ____