BODY GARAGE SKIN CARE HISTORY FORM

Patient _____ **Date** _____

Skin Disease History: (Please circle all that apply)

Acne
Actinic Keratosis
Asthma
Basal Cell **Skin Cancer**
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Rosacea
Squamous Cell Skin Cancer
Other _____
_____

Do you have a family history of Melanoma? YES NO If yes, which relative? _____

Do you have a history of Keloid Scarring (thick or raised scars from cuts or burns)? YES NO

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? YES NO If yes, please describe: _____

What topical medications or creams are you currently using? Retin-A Taxorac Renova Avita Other_____

Are you currently taking or have you taken Accutane in the past 9 months? YES NO

Skin Care History: (If yes, please note when)

Self Tanner	YES NO	_____
Tanned Skin	YES NO	_____
Waxing	YES NO	_____
Tweezing	YES NO	_____
Previous Laser Treatment	YES NO	_____
Permanent lip/brow tattoo	YES NO	_____
Cosmetic Fillers	YES NO	_____
Chemical Peels	YES NO	_____
Microdermabrasion	YES NO	_____
Facials	YES NO	_____

Have you had any previous cosmetic procedures other than listed above? YES NO
If yes, please list: _____

Social History:

Do you exercise? YES NO How often? _____
Do you eat a healthy diet? YES NO How often? _____
Do you consume alcohol? YES NO How often? _____
Level of outdoor activity: (Occupation, sports, boating, beach) High _____ Medium _____ Low _____
Do you currently have a sun burn? YES NO
Do you use a sunscreen? YES NO If yes, what SPF? _____ Do you tan in a tanning salon? YES NO

Please circle which skin type (I to VI) describes you best:

SKIN TYPE	SKIN COLOR	CHARACTERISTICS
I	White; very fair; red or blond hair; blue eyes; freckles	Always burns, never tans
II	White; fair; red or blond hair; blue, hazel, or green eyes	Usually burns, tans with difficulty
III	Cream white; fair with any eye or hair color; very common	Sometimes mild burn, gradually tans
IV	Brown; typical Mediterranean Caucasian skin	Rarely burns, tans with ease
V	Dark Brown; mid-eastern skin types	Very rarely burns, tans very easily
VI	Black	Never burns, tans very easily

Skin Concerns:

What are you looking to improve? List your top 3 cosmetic concerns:

1. _____
2. _____
3. _____

Is there any particular treatment(s) you would like to discuss today? _____

What skin care line are you currently using? _____
Please circle all that apply: Cleanser Toner Moisturizer with sunscreen Eye Cream Night Repair Cream Mask

Would you like to discuss skin care products? YES NO

IPL-Permanent Hair Reduction: (IPL Patients only)

What color is the hair at the treatment site: Black Brown White Grey Red Other _____
What are you currently using/doing to remove hair growth at the treatment site? _____
Any known medical conditions causing increased risk of hair growth? (Hormonal abnormalities, Polycystic Ovary Disease, etc.)? YES NO If yes, please explain: _____
History of abnormal lab studies to check hormonal levels? YES NO
Are you under the care of a Physician? YES NO If yes, please explain: _____
Photosensitive Disorders? (ie., lupus, sun rash, hives, etc.) YES NO
Problems with Circulatory System? (ie., Collagen Disease, Raynaud's , Chilblains, etc.) YES NO
Previous Laser Treatment? YES NO Previous electrolysis? YES NO
Are you currently intentionally tanning? (tanning beds, laying out, etc.) YES NO
Do you wear a broad spectrum sun block every day? YES NO

I, _____, ATTEST TO THE ABOVE TO BE TRUE AND ACCURATE. I UNDERSTAND THAT MY TECHNICIAN RELIES UPON THIS INFORMATION TO PROVIDE A SAFE AND EFFECTIVE TREATMENT.
PATIENT SIGNATURE: _____

FOR STAFF USE ONLY:
Reviewed by: _____ **Date** _____

Body Garage
6301 S. Minnesota Avenue Suite 300
Sioux Falls, SD 57108
605-334-2443

PLASTIC SURGERY & MEDICAL SPA

Medical History

Date: _____
Last Name: _____ First Name: _____ MI: _____
Address: _____ Suite/Apt. No: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____
E-Mail: _____
Occupation: _____ Best way to contact you: _____
Date of Birth: _____ Sex: Male Female
Family Doctor: _____ Dr. Phone No.: _____
Pharmacy: _____ Pharmacy Phone No.: _____

How did you hear about us? _____

If you were referred by one of our patients, please share their name so we may thank them: _____

Past Medical History (Please circle all that apply)

Acne
Anxiety
Arthritis
Asthma
Atrial Fibrillation (Irregular Heartbeat)
Blood Clots
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Thyroid Disease

None of the above

Have you ever had cancer? YES NO If yes, please explain: _____

Have you ever had surgery? YES NO

If so, when and what area? _____
_____

Do you have ANY current or chronic medical illness, specifically: Myasthenia Gravis, Amyotrophic Lateral Sclerosis, or any other neuromuscular disorders? YES NO Please list: _____

Are you currently under a Doctor's care? YES NO If so, for what reason? _____
_____

Medications

(Please enter all current medications without the dosage) _____

_____

_____

Allergies

Are you allergic to Latex? YES NO Are you allergic to Lidocaine (a local anesthetic)? YES NO

Are you allergic to any medications or have any other allergies? YES NO If yes, please list: _____

_____

_____

Please answer all of the following questions

Have you had cold sore breakouts (oral herpes) in the past year? YES NO

Are you on Corticosteroids or Immunosuppressive therapy? YES NO

Have you taken anticoagulants in the last year? YES NO

Have you previously received BOTOX injections before? YES NO

When: _____ Area Treated: _____ Dosage Amount: _____

For women:
-Are you or could you be pregnant? YES NO
-Are you breast feeding? YES NO
-Are your menstrual periods regular? YES NO

I HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS. BY SIGNING THIS DOCUMENT I AGREE THAT THE INFORMATION CONTAINED HEREIN IS TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____ DATE: _____

FOR STAFF USE ONLY:

Reviewed by: _____ DATE: _____