Skin Care & Makeup by Cindy Martell

Patient Health Information Questionnaire

Name: _____ **Date:**_____

Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Home Phone:_____ **Cell Phone:**_____

Date of Birth:_____ **E-Mail:**_____

How did you hear about us? _____

Do you or have you ever had any of the following conditions?

__Aids
__Anemia
__Arthritis
__Auto Immune Deficiency
__Asthma
__Blood Disorder
__Chemotherapy
__Diabetes
__Dizziness
__Epilepsy
__Fainting
__Hay Fever
__Heart Disease
__Hepatitis
__Infection
__Kidney Disease
__Liver Disease
__Lupus Medications
__Melanoma
__Mental Disorder
__Nervous Disorder
__Radiation Treatments
__Respiratory Issues
__Skin Conditions
__Sinus Problems
__Stomach Problems
__Stroke
__Thyroid Disease

Allergies
__Milk
__Aspirin
__Seasonal
__Fruits
__Sugar Cane
__Medications _____
__Cosmetics _____
__Latex/Other_____

Have you ever/are you currently using:

Retin-A, Renova, retinoic acid	Yes/No
Accutane	Yes/No
Prescription Acne meds	Yes/No
Birth Control Pills	Yes/No
Steroids	Yes/No
Are you pregnant?	Yes/No
Are you lactating?	Yes/No

Facial Treatments:

Acid Peels	Yes/No
Botox	Yes/No
Fillers	Yes/No
Tattoo/Permanent Makeup	Yes/No
Waxing	Yes/No
Facial Surgery	Yes/No
Laser Surgery	Yes/No
Microdermabrasion	Yes/No

Have you ever had?

Cold Sore	Yes/No
Fever Blister	Yes/No
If yes, how frequently?	_____

List Current Medications: _____

List any questions you have: _____

SKIN EVALUATION

Type: ___ Normal ___Oily ___Dry ___Combination ___Other

Conditions: ___ Texture ___Sun Damage ___Acne/Oily ___Pigmentation ___Sensitive ___Rosacea
Other_____ Areas of Concern_____

Skin Sensitivity: ___Always ___Usually ___Occasionally ___Rarely ___Never