



FITZPATRICK:

CLIENT INFORMATION:

Last Name: _____ First Name: _____

Date of Birth: _____ Ethnicity/Ancestry/Geographic Genealogy: _____

Occupation: _____

CONTACT INFORMATION:

Address: _____

Phone: (____) _____ Do you prefer: _____ voice mail? or _____ texts?

E-mail address: _____ @ _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____

Phone: _____

PRIMARY PHYSICIAN CONTACT INFORMATION:

Name or Office: _____ Phone: _____

PREFERRED PHARMACY:

Name: _____ LOCATION: _____

ALLERGIES:

Allergen	Reaction
_____	_____
_____	_____

Name:

MEDICATIONS

Name	Dose	Frequency

MEDICAL HISTORY:

Have you had any problems or conditions in the following areas

Sinus	Migraines	Thyroid	Lung disease	Asthma	Emphysema
Hayfever	Heart	Hypertension	Bleeding/Bruising	Veins	
Dyspepsia	Ulcer	Liver	Hepatitis	Colitis	Menstruation
Menopause	PCOS	Cancer	Diabetes	Bladder	Kidney
Anxiety/Depression	HIV/AIDS	Autoimmune	Skin	Acne	
Scleroderma	Neuromuscular				

If yes to any of the above areas, please elaborate:

MAJOR SURGERIES & INJURIES:

Date	Event

OVERNIGHT STAYS AT HOSPITAL (excluding ER visits and childbirth):

Date	Event

LIFESTYLE HISTORY:

Sun Exposure: Hours in sun per week: Spr _____ Sum _____ Win _____ Fall _____

Smoker: NO YES: Packs per day _____

Exercise: NO YES: Type _____; Frequency _____

Women Only: Are you interested in feminine rejuvenation, including improving vaginal and labial tone, dryness, thinning skin, urinary incontinence and sexual satisfaction? YES NO

Name: _____

SKIN HISTORY:

What main concerns brings you to seek treatment?

Brown Spots Acne Scarring Wrinkles Capillaries Veins Dark Circle Anti-aging Melasma

Other: _____

Do you have any new moles or changes existing moles or sores that do not heal? NO

If yes, specify location: _____

Have had suspicious moles removed? NO

If yes, elaborate on pathology results and further interventions needed:

Have you taken Accutane in the past 6 months? NO YES

Do you take blood thinners (Coumadin, aspirin, high dose ibuprofen, Plavix, st. John's Wort, high dose vitamin E) in?

N / Y: medication: _____

Have you ever had cold sores, fever blisters or herpes on your lips? NO YES

If yes, are you using an antiviral treatment medication? NO

If yes, medication _____ last used _____

Do you develop keloid scars? NO YES

FITZPATRICK SKIN TYPE Skin type is based on first 30 to 45 minutes of sun exposure after a winter season of no sun exposure.

Type I Pale white; blond or red hair; blue eyes; freckles. **Always burns, never tans**

Type II White; fair; blond or red hair; blue, green or hazel eyes. **Usually burns, tans minimally**

Type III Cream white/olive; fair with any hair or eye color; quite common. **Sometimes mild burn, tans uniformly**

Type IV Moderate brown; typical Mediterranean skin tone. **Rarely burns, always tans well**

Type V Dark brown; Middle Eastern skin types. **Very rarely burns, tans very easily**

Type VI Deeply pigmented dark brown to black. **Never burns, tans very easily**

Reviewed:

_____ (date)	_____ (initial)	_____ (date)	_____ (initial)	_____ (date)	_____ (initial)	_____ (date)	_____ (initial)
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