indigo

Patient Information and Medical History

Name:_____ Date of Birth:_____

Address:_____ City:_____State: _____ Zip:_____

Cell Phone #:_____ Home Phone #:_____

Email Address:_____

Employer:_____ Occupation:_____

Emergency Contact Name:_____ Phone Number:_____

How Did You Hear About Us:_____

Do We Have Permission To Use Your Photos For Educational Purposes:_____Yes_____No

Do We Have Permission To Post Your Photos To Social Media:_____Yes_____No

Do We Have Permission To Post Your Photos To Our Website:_____Yes_____No

Primary Physician:_____ Dermatologist:_____

Do You Have Any Allergies To Any Medications:_____

Do You Have Any Food Allergies:_____

Do You Have A Latex Allergy:_____

In The Past 6 Months Have You Had A Rash, Swelling, Peeling, Or Hives:_____Yes_____No

If Yes Please Explain:_____

What Medications, Vitamins, Or Supplements Are You Taking:_____

_____

_____

Are You Pregnant:_____ Are You Nursing:_____

Are You Taking Or Have You Ever Taken Acutane:_____

Are You Using or Have You Ever Used Retin-A On Your Skin:_____

Are You Using Or Have You Ever Used Renova On Your Skin:_____

Are You Using Or Have You Ever Used Hydroquinone on Your Skin:_____

What Skin Care Products Do You Currently Use:_____

Do You Use A Daily SPF:_____ If Yes What Grade:_____

How Would You Describe Your Skin:_____Oily_____Dry_____Combination_____Sensitive

What Is Your Ethnic Background:_____

When Was The Last Time You Were Exposed To The Sun Other Than Normal Exposure:_____

When Was The Last Time You Used A Self Tanner Or Had A Spray Tan:_____

What Concerns You About The Overall Appearance Of Your Skin(Please Check All That Apply)

___Acne	___Acne Scarring	___Age Spots	___Aging Hands
___Aging Skin	___Blackheads	___Body Acne	___Broken Blood Vessels
___Broken Capillaries	___Brown Spots	___Cellulite	___Cysts
___Dehydrated Skin	___Dull Complexion	___Facial Hair	___Facial Veins
___Fine Lines	___Frequent Breakouts	___Hyperhidrosis	___Large Pores
___Loose Skin	___Loss Of Lashes	___Loss of Brows	___Melasama/Brown Patches
___Oily Skin	___Redness	___Rosacea	___Sagging Skin
___Scarring	___Skin Tags	___Skin Texture	___Spider Veins
___Stretch Marks	___Sun Damage	___Thin Lips	___Toenail Fungus
___Under Eye Circles	___Unwanted Fat	___Unwanted Hair	___Wrinkles

Other_____

Are You In Good Health Overall:_____Yes_____No_____Concerns

Are There Any Health Problems We Should Be Advised Of:_____

Are You Currently Being Treated For ANY Medical Condition:_____

Do You Have Any Form Of A Herpetic Virus:_____

If Yes When Was Your Last Outbreak:_____

Do You Smoke:_____Yes_____No_____Frequency If Yes

Do You Have An Internal Pacemaker:_____

Do You Have An Internal Defibrillator:_____

Do You Have Any Implanted Surgical Devices:_____

Please Check All That Apply:

___Allergies	___Asthma	___Arthritis	___Autoimmune Illness
___Bleeding Disorder	___Cancer	___Clotting Disorder	___Eczema
___Lung Disease	___Diabetes	___Hay Fever	___Heart Disease
___Hepatitis	___Herpes	___HIV/AIDS	___Lupus
___Menopause	___Mental Illness	___Photosensitivity	___Skin Cancer
___Stroke/TIA	___Melanoma	___Psoriasis	___Tuberculosis

I ATTEST THAT THE ABOVE INFORMATION TO BE TRUE, KNOWING THAT MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.

Patient Signature:_____Date:_____

Patient Name(Print):_____

Relationship To Patient If Signer is Under The Age of 18:_____

Provider Signature:_____Date:_____

Doctor Signature:_____Date:_____