Mark Grimsley, MD
Aesthetics
www.MarkGrimsley.md

Medical History and Cosmetic Interest Questionnaire

Name ____ Date ___________________

<u>Skin Care Questions</u>:

These answers help us determine appropriate treatments and any special care or cautions.

1.	Are you taking any aspirin, anti-inflamatories or blood thinners?	Yes	No
2.	Have you ever used Retin A, Renova or Accutane?	Yes	No
3.	Have you had skin tumors, skin cancer or melanoma?	Yes	No
4.	Do you have any skin disorders? Please Describe	Yes	No
5.	Do you have any open sores, herpes, or fever blisters?	Yes	No
6.	Do you have sensitive skin or bruise easily?	Yes	No
7.	Have you had any cosmetic or aesthetic procedures before?	Yes	No
8.	Have you had any permanent cosmetics done?	Yes	No
9.	Are you using bleaching creams or self tanning agents?	Yes	No
10.	Have you ever had gold or silver treatments of any kind?	Yes	No
11.	After an injury do you get raised scars or light/dark areas?	Yes	No

Provide explanations below for each "yes"

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<u>General Medical Health Questions</u>:

1.	Are you or could you be pregnant?	Yes	No
2.	Are you breast feeding?	Yes	No
3.	Are you using birth control pills or taking hormones?	Yes	No
4.	Do you have a history of neurologic problems or Bell's Palsy?	Yes	No
5.	Do you have a history of cancer?	Yes	No
6.	Any infectious illness, such as Hepatitis or HIV/AIDS?	Yes	No
7.	Do you smoke? How many cigarettes a day?	Yes	No
8.	Do you drink alcohol? How many glasses daily?	Yes	No
9.	Do you have Diabetes?	Yes	No
10.	Have you had any skin disorders?	Yes	No
11.	Do you have a history of fainting?	Yes	No
12.	Have you ever had a history of numbing/tingling to face?	Yes	No
13.	Have you ever had any blood clotting abnormalities?	Yes	No
14.	Are you under the care of a physician or dermatologist?	Yes	No
15.	Are you currently being treated for any specific condition?	Yes	No

Provide explanations below for each "yes"

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Please list all prescribed and over the counter medications, vitamins and supplements you take:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

ALLERGIES:

Do you have any drug or food allergies (soy products or latex gloves)? Yes No

Please explain:

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What would you like to change most about your skin and/or body?

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Areas of Interest or Concerns: (Please check all that apply)

- [ ] Skin Care Advice or Products
- [ ] Weight Control/ Body Sculpting
- [ ] Skin Rejuvenation/Tightening
- [ ] Hair Removal
- [ ] Spider Veins
- [ ] Microdermabrasion
- [ ] Sun Damage, Liver & Age Spots
- [ ] Wrinkles
- [ ] Hair Restoration/Thickening
- [ ] Resurfacing
- [ ] Acne
- [ ] Botox
- [ ] Fillers
- [ ] Chemical Peels
- [ ] Massage
- [ ] Hyperhydrosis (sweating)
- [ ] Cellulite Treatment
- [ ] Stretch Mark Treatment

I affirm that I have answered all questions truthfully to the best of my knowledge.

Signature ____