Kingwood Derm Spa

Steven J. Smith
19701 Kingwood Dr., BLDG. 6
Kingwood, Texas 77339

MEDICAL HISTORY (please print)

LAST NAME_____ **FIRST NAME**_____ **M**____**F**____ **DOB** _____

REASON FOR VISIT _____

MEDICATIONS

Please list all the medications you are currently taking, including strength and number of times per day taken.

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY

Please mark any of the diagnoses that apply to you, please include the year you were diagnosed.

☐ Acid Reflux	☐ Coronary Artery Disease	☐ Migraine Headaches
☐ Allergic Rhinitis	☐ Depression	☐ Osteoarthritis
☐ Anxiety	☐ Diabetes	☐ Pacemaker
☐ Asthma	☐ Emphysema	☐ Seizure Disorder
☐ Atrial Fibrillation	☐ Gout	☐ Thyroid Disease
☐ Attention Deficit	☐ Hepatitis	
☐ Cancer (Breast, Ovary, Uterine)	☐ High Blood Pressure	
☐ Cancer (Lung)	☐ High Cholesterol	
☐ Cancer (Prostate)	☐ HIV/AIDS	
☐ Congestive Heart Failure	☐ Irritable Bowel Syndrome	

DRUG ALLERGIES

If you are allergic to any medications please write the name of the medication and the type of reaction you have to the medication.

☐ Anesthetics	☐ Aspirin	☐ Codeine	☐ Latex	☐ Penicillin	☐ Sulfa

☐ Other, please explain
☐ No Allergies

_____

_____

_____

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SURGICAL HISTORY

Please mark any of the surgeries that apply to you and give the year it was done.

□ Appendix	□ Heart Bypass	□ Tonsillectomy
□ Artery Bypass	□ Hysterectomy	□ Osteoarthritis
□ Balloon Angioplasty	□ Knee Surgery	□ Tubal Ligation
□ Cardiac stent	□ Mastectomy	□ Seizure Disorder
□ Colon Surgery	□ Organ Transplant	□ Valve Replacement
□ Disc Surgery	□ PE Tubes	□ Vasectomy
□ Facial Surgery	□ Prostate Surgery	□ Breast Implants
□ Gallbladder	□ Splenectomy	□ Liposuction

FAMILY HISTORY

Please mark the disease and circle the family member who has had this disease.

(F= Father, M= Mother, B= Brother, S= Sister, GP= Grandparent)

□ Breast Cancer M S GP	□ Heart Disease F M B/S GP	□ Adopted
□ Colon Cancer F M B/S GP	□ Melanoma F M B/S GP	□ Thyroid disease F M B/S GP
□ Diabetes F M B/S GP	□ Prostate Cancer F B GP	

SOCIAL HISTORY

We would like to get to know you better, please fill out the information below.

Marital Status □ Married □ Single □ Divorced □ Widowed

Occupation_____

Name of Spouse_____

Names of Children_____

Exercise per week_____

Smoking □ No □ Yes (packs/day) _____ Alcohol □ No □ Yes (drinks per day)_____

HEALTH HISTORY

Do you have a living will? □ No □ Yes Date last reviewed _____

When was your last complete physical? _____

When was your last Tetanus booster? _____

Have you received a pneumonia vaccine? □ No □ Yes Date of vaccine_____

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MEN AND WOMEN OVER AGE 50

When did you last have:
A stool specimen tested for blood/cancer? ☐ No ☐ Yes _____
A colonoscopy or sigmoidoscopy to check for colon cancer? ☐ No ☐ Yes _____
An exercise stress test? ☐ No ☐ Yes _____
An EKG? ☐ No ☐ Yes _____

FOR MEN OVER 50

When was your last PSA blood test? ☐ No ☐ Yes _____

FOR WOMEN ONLY

Are you pregnant? ☐ No ☐ Yes If yes, how far along?_____
When was your last mammogram? ☐ No ☐ Yes _____ At which facility_____
When was your last pap smear? ☐ No ☐ Yes _____ Performed by: _____
When was your last bone density scan? ☐ No ☐ Yes _____
When was the first day of your last menstrual period?_____
What form of contraception do you currently use? ☐ No ☐ Yes _____

QUESTIONS RELATING TO SKIN/SKIN CARE

☐ YES ☐ NO Have you ever had herpes, cold sores, fever blisters, keloids, or hives? Circle any yes answer
☐ YES ☐ NO Is your family prone to vascular blemishes?
Spider Veins_____ Varicose leg veins_____ Cherry Angioma_____ Facial Capillaries_____ Rosacea_____
☐ YES ☐ NO Have you ever visited a dermatologist, plastic surgeon, cosmetic dentist, or other skin care clinic?
List_____
☐ YES ☐ NO Have you ever used Retin-A or a similar product?
☐ YES ☐ NO Do you use skin products such as moisturizer, cleanser? What Brand?_____
☐ YES ☐ NO Do you suntan?
☐ YES ☐ NO Do you use sunscreen?

Is your skin: ☐ Dry ☐ Oily ☐ Normal ☐ Combination

Are you: ☐ Fair ☐ Olive ☐ Asian ☐ Hispanic ☐ Native American ☐ African American?

What are your concerns with your skin?

_____

_____

Patient Signature_____Date _____

Provider_____Date_____

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Please answer the following questions by circling the number which best describes you. Your clinician will total the score during the consultation. If skin type V or VI: You need to schedule a SKIN SPOT TEST (Which would mean you have to come in for a consult).

My eye color is:	Light Blue Blue/Green Green/Gray/Golden Hazel/Light Brown Brown	0 1 2 3 4
My natural hair color at age 18 was:	Red Blonde Light Brown Medium to Dark Brown Black	0 1 2 3 4
The color of my skin that is not normally exposed to sun is:	Pink to Reddish Very Pale Pale with a Beige tint Light Brown Medium to Dark Brown Dark Brown/Black	0 1 2 3 4 5
If I go into the sun for an hour or so without sunscreen and have not been in the sun for weeks, my skin will:	Burn, Blister and Peel Burn, little or no color change Burn, then tan Get pink, then tan Just tan Just gets darker My skin color is dark	0 1 2 3 4 5 6
When was the last time the area to be treated was exposed to sunlight, tanning booths or tanning cream:	Longer than one month ago Within the past month Within the past two weeks Within the past week	1 2 3 4

If your score is:	Your skin type is:	Total Score:
0-3	I	
4-7	II	
8-11	III	
12-15	IV	
16-19	V	
20-24	VI	

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PATIENT CONSENT FORM

Consent for the taking and publication of photographs, videotape, and/or computer images

I, _____, hereby consent that photographs, videotape, and/or computer imaging may be taken of me or of parts of my body under the following conditions:

☐ Pre-treatment and post-treatment photographs will be taken of my treatment for medical record purposes. The photographs will be taken by my physician or staff member of my physician. I understand that these photographs will be the property of the attending physician and *Kingwood DermSpa.*

☐ Pre-treatment and post-treatment photographs will be taken of my treatment for medical record purposes. Such photographs and/or videotape shall be used only for medical records, teaching, publication, marketing, or scientific research by my physician and *Kingwood DermSpa,* provided that in any such publication the use of my name and identity is kept confidential and protected. Such photographs may be edited at the discretion of my physician to protect my confidentiality or emphasize the treated area.

☐ I have had the opportunity to discuss this consent with my attending physician or a qualified staff member of *Kingwood DermSpa.* I agree that all of my questions have been answered. I hereby waive all rights I might have to such photographs, videotape, and computer images and do hereby release, discharge, and save harmless my physician & *Kingwood DermSpa* and their respective managers & employees from all such claims and liabilities whatsoever in law and in equity arising from the use of such photographs, videotape and computer images described above.

☐ I have **declined** having any photos taken by my attending physician or any staff of *Kingwood DermSpa.* By signing below, I am indicating that I understand that I will be unable to visualize the treatment changes over time.

I have read and fully understand this Photo/Video/Computer Imaging Consent and agree to all of its terms.

Patient Signature _____, Date _____

Witness Signature _____, Date _____