New Patient Information Sheet

SkinMedíc
A Skin Health & Age Management Clinic
— Established 1998 —

1727 S. Cheyenne Ave. Tulsa Ok 74119
Phone (918) 587-7546 • Fax (918) 583-2776

Please Print

Name: ______________________ Occupation: ______________________

Address: ______________________ Email: ______________________

City: ______________________ State: __________ Zip: __________

What phone number is best for us to call you? ______________________ ☐ Home ☐ Cell ☐ Work

Date of Birth: __________ Pharmacy Name and Number: ______________________

Allergies ______________________ Seasonal? ☐ Yes ☐ No

Allergies to medications: ______________________

Allergies to Foods: ______________________

Allergies to wool/fibers: ______________________

How did you learn about SkinMedic?

☐ Friend ☐ Dr. or Nurse ☐ Newspaper ☐ Magazine ☐ SkinMedic Website ☐ Another Website

☐ Facebook ☐ Phone Book ☐ Internet Directory

What is the primary purpose of today's visit? ______________________

Please list (3) things you would like to change about your skin:

1. ______________________
2. ______________________
3. ______________________

Skin Care Questionnaire

Do you sunbathe: ☐ Yes ☐ No ☐ Sun? ☐ Tanning Booth? ☐ Last Exposure:

Do you wear sunscreen/sunblock? ☐ Always ☐ Sometimes ☐ Never

Do you use self-tanning? ☐ Yes ☐ No Last Application: ______________________

Do you have problems with healing or scarring? ☐ Yes ☐ No Any recent changes in hair color/thickness/texture? ☐ Yes ☐ No

Mark any previous hair removal methods and how long using each treatment:

☐ Shaving: ________ ☐ Waxing: ________ ☐ Bleaching: ________ ☐ Sugaring: ________ ☐ Threading: ________

☐ Electrolysis: ________ ☐ Tweezing: ________ ☐ Laser/Light Removal: ________

Fitzpatrick Skin Scale:

Check the box of your skin's response after your first seasonal/summer sun exposure without sunblock protection after 45 minutes:

☐ White-always burn/never tan ☐ White-usually burn/tan slightly ☐ White-sometimes mildly burn/tan average
☐ Mod. Brown/barely burn/tan easily ☐ Dk Brown-very rarely burn/tan very easily ☐ Black never burn/tan very easily

Do you consider your complexion to be: ☐ Light ☐ Medium ☐ Olive ☐ Dark
Do you consider your skin to be: ☐ Oily ☐ Dry ☐ Combination ☐ Sensitive

Do you have a history of or are you experiencing a new onset of acne breakouts? ☐ Yes ☐ No

If yes, please give details regarding onset, duration, if isolated or clusters, and if occurrence is timed to menstruation cycle:

____

____

Please complete the other side.

New Patient Information Sheet (Continued)

Please name brand of products you are currently using:

Cleanser/Soap:__________ Toner/Astringent:__________ Scrub:__________

Moisturizer:__________ Other (describe):__________

Sunscreen/Sunblock:__________ Cosmetics:__________

Are you completely satisfied with your current program? ☐ Yes ☐ No How much do you feel you spend on products in one year?__________

(Females Only)

Age onset of menses?__________ Normal number of days in cycle:__________ Date of last period:__________

Are your periods regular? ☐ Yes ☐ No Are you on birth control pills? ☐ Yes ☐ No HRT?__________

Are you currently or attempting to become pregnant? ☐ Yes ☐ No

What procedures/health issues are you interested in learning more about?__________

Patient Health

Please list any medications you are presently taking. Pharmacy:__________

Medication Name:	For what purpose:
1.	
2.	
3.	

Past/Current Medical History (Please check any that apply)

☐ High Blood Pressure	☐ Seizures	☐ Smoker	☐ Alcohol	☐ Diabetes
☐ Stroke	☐ Heart Attack	☐ Nutritional Compromise	☐ HRT	☐ BC Pills
☐ Surgery	☐ Hives	☐ Cold Sore/Fever Blisters	☐ Herpes	☐ Skin Cancer
☐ Eczema	☐ Seborrheic Dermatitis	☐ Psoriasis	☐ Acne	☐ Retin-A
☐ Accutane	☐ Phenol	☐ Trichloroacetic Acid or Blue Peel		☐ Hydroquinone
☐ Laser	☐ Scars	☐ Keloids	☐ Tattoos	☐ Eye Surgery
☐ Wear Contacts	☐ Plastic Surgery	☐ Other?__________		

Please describe any of the above that you checked:__________

ATTENTION:

In order to better serve our clientele, and because we know your time is as valuable as ours, we require 24-hour notice of cancellation if at all possible. Certainly some circumstances are unavoidable, yet most do not excuse lack of prompt notification to our staff or a message left at 918-587-7546 (SKIN).

***A $45.00 office call charge may be applied at the discretion of the management.**

SIGNATURE:__________

Signs of Aging

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Let us know about your concerns & we will design a skin care program that fits your fits your needs and budget.

Place a check in the circle of the areas of the face that bother or trouble you.

- ○ Forehead Lines
- ○ Crepey Skin (droopy eyelids)
- ○ Freckles & Pigmentation
- ○ Blood Vessels
- ○ Sunken Temples
- ○ Scarring (acne)
- ○ Acne
- ○ Vertical Lip Lines (smoker's lines)
- ○ Marionette Lines (down turned corners)
- ○ Thinning Skin
- ○ Orange Peel Chin
- ○ Neck Bands (crepey neck)
- ○ Frown Lines
- ○ Crow's Feet
- ○ Dark Circles
- ○ Sunken Cheeks
- ○ Enlarged Pores
- ○ Crooked Nose
- ○ Ear Lobes
- ○ Philtrum
- ○ Nose-to-Mouth Lines
- ○ Unwanted Hair
- ○ Cupid's Bow
- ○ Thin Lips
- ○ Poor Skin Texture & Fine Lines
- ○ Skin Tags

Notes and other concerns

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