sōna DERMATOLOGY® & MEDSPA

PATIENT HEALTH HISTORY

Full Name (Last, First, MI, "Nickname") _____ **Date of Birth** / / **Birth Sex** M / F **Race(s)** _____ **Today's Date:** / /

Email _____ **Height:** _____ **Weight:** _____

Phone Numbers *Provide your contact number(s) and check the box below for your preferred contact number.*

☐ **Mobile** _____ ☐ **Home** _____ ☐ **Work** _____

May we leave a detailed message? ☐ **Yes** ☐ **No**

Home Address _____ **City** _____ **State** _____ **Zip Code** _____

Emergency Contact (Last, First) _____ **Phone** _____

Pharmacy Name _____ **Pharmacy Address** _____ **Phone** _____

Primary Care Provider - PCP (First & Last Name) _____ **Phone** _____

Referring Provider (First & Last Name) _____ **Phone** _____

☐ *Check if you do not have a PCP* ☐ *Check if PCP is same as Referring Provider*

MEDICAL HISTORY

Select past and present medical conditions you have experienced:

☐ **None**
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation *(Irregular Heartbeat)*
☐ *Bone Marrow Transplantation*
☐ Depression
☐ Diabetes
☐ Heart Disease/Cardiac Condition
☐ Hepatitis
☐ Herpes
☐ HIV / AIDS
☐ Hirsutism
☐ Hypertension *(High Blood Pressure)*
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Seizures
☐ PCOS
☐ Shingles
☐ Stroke

Cancers Other Than Skin: *Include type/location and treatment(s)* _____

Additional Medical Conditions: _____

PAST SURGERIES

☐ **None OR List all past surgeries:** _____

SKIN DISEASE HISTORY

☐ **None** If you have had any of the following skin conditions, provide details below *(including treatment dates and location(s))*:

SKIN CANCERS

☐ Basal Cell Carcinoma _____
☐ Melanoma _____
☐ Precancerous Moles _____
☐ Squamous Cell Carcinoma _____

☐ Additional skin conditions, infections or allergies:
_____
_____

SKIN CONDITIONS

☐ Acne _____
☐ Cold Sores/Fever Blisters _____
☐ Dry Skin _____
☐ Eczema _____
☐ Psoriasis _____
☐ Rosacea _____
☐ Vitiligo _____

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF? _____ **Tanning salon usage?** ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No If yes, which relative(s)? _____

MEDICATIONS

List all medication names and dosages including over the counter, herbal supplements, prescription creams & skin care products.

☐ **No current medications** *(Examples: Retin-A, Renova, Differin, Tazorac, glycolic/AHA products)*

_____
_____
_____

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ALLERGIES

List all allergies and reaction(s), including medication, food, and environmental.

☐ **No known allergies**

SOCIAL HISTORY

TOBACCO USAGE

☐ Never ☐ Former ☐ Current If a smoker, number of packs per day: _____ Total years smoking: _____ Tobacco Type: _____

ALCOHOL USAGE

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women?

Number of Days_____ ☐ None ☐ Decline to Specify

OCCUPATION: _____

AGE 65+ ONLY (SKIP THIS SECTION IF YOUNGER THAN 65)

Have you ever received a **pneumonia vaccination**? ☐ Yes ☐ No

Year of most recent pneumonia vaccination: _____ Vaccination(s) received (check all that apply): ☐ PPSV23 ☐ PCV13 ☐ Unsure

Do you have an **advance care plan/living will**? ☐ Yes ☐ No ☐ Decline to specify *(If no or decline, skip remaining questions)*

Do you have a healthcare proxy? ☐ Yes ☐ No Designee's Name/Phone Number: _____

Which statement(s) reflect your wishes: ☐ Do not intubate ☐ Do not resuscitate ☐ Full cardiopulmonary resuscitation

REVIEW OF SYSTEMS

Have you experienced any of these symptoms in the past week:

☐ **None** ☐ Fever/chills ☐ Rash ☐ Joint pain

ALERTS

Select all that apply:

☐ **None**
☐ Allergy to lidocaine
☐ Bleeding Disorder
☐ Blood Thinners
☐ Breastfeeding
☐ Diastatis Recti
☐ Eating Disorder
☐ History of hernia or hernia repair
☐ History of tanning bed usage
☐ Hormone Replacement Therapy
☐ Hyperhidrosis
☐ Hyperpigmentation *(Skin Darkening)*
☐ Hypopigmentation *(Skin lightening)*
☐ Immunosuppression
☐ Irregular Periods
☐ Isotretinoin *(Accutane)*
☐ Kidney disease
☐ Latex allergy
☐ Liver disease
☐ Lupus
☐ Menopausal *(1st 12 months)*
☐ Metal or other implants
☐ Organ transplant
☐ Pacemaker/Electric Device
☐ Pregnancy or planning pregnancy
☐ Problems healing
☐ Problems scarring *(hypertrophic or keloid)*
☐ Radiation/Chemotherapy
☐ Rapid Heartbeat/Sensitivity to Epinephrine
☐ Tattoos
☐ Thyroid problems

ADDITIONAL QUESTIONS

How did you hear about us? _____ ☐ Referring Provider

Have you had any previous laser, skin, Botox or filler treatments? _____

Which of the following concerns do you have about your skin/body?

☐ Acne
☐ Age Spots
☐ Aged Skin
☐ Cellulite
☐ Dry Skin
☐ Enlarged pores
☐ Hair Removal
☐ Leg Veins
☐ Melasma
☐ Oily Skin
☐ Pigment Changes
☐ Redness
☐ Rosacea
☐ Scars
☐ Sensitive Skin
☐ Skin Laxity
☐ Skin Texture
☐ Spider Veins
☐ Stubborn or pinchable fat
☐ Sun Damage
☐ Sweat/Odor
☐ Uneven Skin Color
☐ Whiteheads
☐ Wrinkles
☐ Other:

Which of the following services would you like to learn more about?

☐ Acne treatment
☐ Age spot treatment
☐ Botox
☐ Fat reduction
☐ Filler Injections
☐ Laser Hair Removal
☐ Laser Skin Rejuvenation
☐ Laser Vein Treatment
☐ Melasma
☐ MiraDry sweat & odor reduction
☐ Pigment Treatment
☐ Redness/Vessels
☐ Rosacea Treatment
☐ Scar Treatment
☐ Skin Resurfacing
☐ Skin Tightening
☐ Sun Damage Repair
☐ Wrinkle Treatment
☐ Other: