Medical Health History and Skin Care Profile

Help us get to know you a little bit better by kindly filling out the information below. Should you have any questions, please let us know and we would be happy to assist.

Title: ☐ Mr. ☐ Mrs. ☐ Ms. First & Last Name: _____

Clinic Name: _____

Email Address: _____

Address: _____ City: _____ Province: _____

Postal/Zip Code: _____ Telephone Number: (_____) _____ Birthday: _____

Occupation: _____ Emergency Contact Name: _____

Emergency Contact Number: _____ Relationship: _____

ALLERGIES and SENSITIVITIES (please list):

_____

SKIN CONDITIONS (select all that apply)

- ☐ Acne: Mild, Moderate, Cystic **(please circle)**
- ☐ Rosacea
- ☐ Acne scars
- ☐ Aging Skin
- ☐ Back/Chest Acne
- ☐ Blackheads
- ☐ Whiteheads
- ☐ Blistering Sunburns (past/present)
- ☐ Burn
- ☐ Cosmetic Product Reaction
- ☐ Dark under-eye circles
- ☐ Dermatitis
- ☐ Dry skin
- ☐ Eczema
- ☐ Elastosis (Sagging skin)
- ☐ Enlarged pores
- ☐ Freckles
- ☐ Herpes Simplex (cold sores)
- ☐ Hyperkeratinisation
- ☐ Hyperpigmentation (age spots)
- ☐ Hypopigmentation (white spots)
- ☐ Keratosis Pilaris (skin bumps)
- ☐ Lines/wrinkles
- ☐ Moles
- ☐ Pseudo Folliculitis Barbae (Ingrown hairs)
- ☐ Psoriasis
- ☐ Salicylic/Aspirin Allergy
- ☐ Scarring (Raised, depressed or flat)
- ☐ Keloid scarring

- ☐ Seborrhea (excessive oiliness)
- ☐ Sensitive skin
- ☐ Aloe Allergy
- ☐ Skin cancer (past/present)
- ☐ Skin discoloration
- ☐ Tattoos
- ☐ Cherry Haemangiomas
- ☐ Stretch marks
- ☐ Sun Damage
- ☐ Telangiectasia
- ☐ Uneven Texture
- ☐ Vitiligo

Please list your top 3 skin care concerns in order of priority:

1. _____

2. _____

3. _____

SUN EXPOSURE

How do you react to the sun?

- ☐ Always burn, never tan
- ☐ Burn first, tan with difficulty
- ☐ Burn first, tan with ease
- ☐ Seldom burn, tan with ease
- ☐ Never burn, always tan

Do you use sun protection?

- ☐ Yes
- ☐ No

Sun Exposure?

- ☐ Occasional
- ☐ Occupational
- ☐ Recreational

When were you last exposed to the sun?

- ☐ Less than a week
- ☐ 2 weeks
- ☐ 1 month

Do you use tanning beds?

- ☐ Yes
- ☐ No

If yes, how often? ☐ Weekly ☐ Monthly ☐ Several times a week ☐ A few times per year

Do you use self tanner?

- ☐ Yes
- ☐ No

COSMETIC MEDICAL HISTORY

Are you under the care of a dermatologist?

- ☐ Yes
- ☐ No

Reason for treatment? _____

Do you currently use, or have you previously used?

- ☐ Accutane
- ☐ Retinol
- ☐ Hormone replacement therapy

If yes, when: _____

Have you had plastic surgery?

- ☐ Yes
- ☐ No

If yes, what procedure: _____ when: _____

Have you had cosmetic injections?

- ☐ Yes
- ☐ No

If yes, what: _____ body part: _____ when: _____

Have you had any of the following cosmetic treatments (select all that apply):

- ☐ Peels
- ☐ Hair Reduction
- ☐ Photo facial
- ☐ Laser Resurfacing
- ☐ Body/Face Contouring
- ☐ Micro-needling
- ☐ Microblading

GENERAL MEDICAL HISTORY

Do you have or ever had skin cancer?

- ☐ Yes
- ☐ No

When: _____ Where: _____ Type: _____

Please list all current medications:

_____

_____

Please list all relevant surgeries and when:

_____

Please select all that apply:

- ☐ Anxiety depression
- ☐ Cancer
- ☐ Constipation
- ☐ Contact lenses
- ☐ Crohn's/IBS
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Pacemaker
- ☐ Arrhythmia or Dysrhythmia
- ☐ Hearing Aids
- ☐ Heart Disease
- ☐ Hepatitis B or C
- ☐ HIV
- ☐ Lupus
- ☐ Arthritis
- ☐ Asthma
- ☐ Implants (metal, silicone)
- ☐ Thyroid disorder
- ☐ Birth control
- ☐ IUD
- ☐ Menopause
- ☐ Pregnant
- ☐ Breastfeeding

LIFESTYLE

Have you had children?

- ☐ Yes
- ☐ No

How would you rate your stress level?

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- ☐ High
- ☐ Moderate
- ☐ Low

On average how much sleep do you get per night?

- ☐ More than 8 hours
- ☐ 6-8 hours
- ☐ Less than 6 hours

How would you rate your diet?

- ☐ Healthy
- ☐ Poor
- ☐ Vegetarian/Vegan
- ☐ Restricted

Please list any dietary supplements or vitamins you are currently taking:

_____

How much of the following do you have each day?

Coffee: _____ Water: _____

Alcohol: _____ Cigarettes: _____

How often do you exercise?

- ☐ Less than 2 days a week
- ☐ 3 days a week
- ☐ More than 5 days a week

A complete and accurate health history is important to ensure that it is safe for you to receive treatment and to determine the treatment and products that are most beneficial. Treatment protocol is based solely on the information provided. By signing below, you understand that the information that you have provided above is the most accurate to your knowledge and will be confidential retained exclusively by Sharplight.

Date: _____ **Signature:** _____