Peninsula Glow
MEDICAL SPA

Patient Medical History

Name: _____ **Date**: _____

Date of Birth: _____

Are you currently under the care of a physician? (Circle one) *Yes* *No*

If yes, name of physician: _____

Are you currently under the care of a dermatologist? (Circle one) *Yes* *No*

If yes, name of dermatologist: _____

Significant History:

Accutane in the last 6 months:	**Yes**	**No**	Retin-A Use:	**Yes**	**No**
Cold Sores/Herpes:	**Yes**	**No**	Seizure Disorders:	**Yes**	**No**
Diabetes:	**Yes**	**No**	Skin Disease/Infections**:**	**Yes**	**No**
Keloids (raised scarring):	**Yes**	**No**	Tattoos or Permanent Make Up:	**Yes**	**No**

Health History: _____

_____

Surgical History: _____

_____

Medications: (please list) _____

_____

Allergies: _____

FOR FEMALE PATIENTS

Are you pregnant or trying to become pregnant? (Circle one) *Yes* *No*

Are you breastfeeding? (Circle one) *Yes* *No*

Which of the following best describes your skin type? (Circle one skin type number)
Ethnicity: _____

- **I.** Always burns, never tans
- **II.** Always burns, sometimes tans
- **III.** Sometimes burns, always tans
- **IV.** Rarely burns, always tans
- **V.** Brown, moderately pigmented skin
- **VI.** Black skin

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the doctor or nurse of my current medical health conditions and update this history as current medical history is essential for the caregiver to execute appropriate treatment procedures.