



part of the medical practice of Clovis E. Manley, MD

Medical History and Skin Care Questionnaire

Name _____ Age _____ Sex _____ Date _____

Address _____ Phone _____

Who can we thank for referring you to us? _____

If not referred, how did you hear about us? _____

From time to time we may contact you regarding specials, etc. How would you like for us to get in contact with you? _____ (phone, email, mail) at _____.

Medical History

Medical Conditions

(list all medical conditions, problems, or diseases that you have)

- _____
- _____
- _____
- _____

Check any condition that applies to you:

- | | | | |
|---|---|----------------------------------|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer- Type _____ | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Neurological disease |
| <input type="checkbox"/> Keloid formation | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Lupus | <input type="checkbox"/> Myasthenia gravis |
| <input type="checkbox"/> Other Muscle disease | | | |

Current Medications

(list all prescription, over-the-counter, and herbal medications you take)

- | | |
|---------|---------|
| • _____ | • _____ |
| • _____ | • _____ |
| • _____ | • _____ |
| • _____ | • _____ |

Allergies _____

Social History

I use tobacco I use other drugs

Amount of alcohol consumed per week _____

Women Only

First day of your last menstrual period _____

Type of birth control used _____

Check all that apply:

- Hysterectomy Tubal ligation Pregnant I could be pregnant

Skin Care Questionnaire

SKIN HISTORY

- | | Yes | No |
|---|--------------------------|--------------------------|
| Have you had skin cancer?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a precancerous skin lesion? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have problems with scarring from skin injuries?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get keloids? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a skin condition?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have herpes breakouts on your skin? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a skin rash that comes and goes
in the same place? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a history of cold sores?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have acne? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever taken Accutane?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you allergic to fragrances or scents?..... | <input type="checkbox"/> | <input type="checkbox"/> |

PRESENT SKIN CONDITION

- | | | |
|---|--------------------------|--------------------------|
| Do you have sun-damaged skin? | <input type="checkbox"/> | <input type="checkbox"/> |
| brown spots or age spots? | <input type="checkbox"/> | <input type="checkbox"/> |
| uneven skin color?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| any skin pigmentation problems?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| broken facial capillaries?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| facial wrinkles? | <input type="checkbox"/> | <input type="checkbox"/> |
| oily skin? | <input type="checkbox"/> | <input type="checkbox"/> |
| dry skin? | <input type="checkbox"/> | <input type="checkbox"/> |
| clogged pores? | <input type="checkbox"/> | <input type="checkbox"/> |
| whiteheads or blackheads? | <input type="checkbox"/> | <input type="checkbox"/> |
| facial spider veins? | <input type="checkbox"/> | <input type="checkbox"/> |
| leg spider veins or varicose veins? | <input type="checkbox"/> | <input type="checkbox"/> |
| moles you would like removed? | <input type="checkbox"/> | <input type="checkbox"/> |
| crusty or scaly skin lesions that never go away?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| moles that have changed shape or color? | <input type="checkbox"/> | <input type="checkbox"/> |

COSMETIC HISTORY

- | | Yes | No | |
|--|--------------------------|--------------------------|-------|
| Have you had facial plastic surgery? | <input type="checkbox"/> | <input type="checkbox"/> | Date |
| other facial surgery? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| collagen or silicone injections? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Botox® injections? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| glycolic peels? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| TCA or phenol peels? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| dermabrasion or microdermabrasion? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| skin resurfacing? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| photorejuvenation? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| intense pulse light treatment? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| laser treatment of veins? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| sclerotherapy (injection) of veins? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

COSMETIC HISTORY (cont'd)

	Yes	No	Date
Have you had hair removal by electrolysis?	<input type="checkbox"/>	<input type="checkbox"/>	_____
laser?	<input type="checkbox"/>	<input type="checkbox"/>	_____
waxing?	<input type="checkbox"/>	<input type="checkbox"/>	_____
intense pulse light?	<input type="checkbox"/>	<input type="checkbox"/>	_____
other means?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had other cosmetic procedures?	<input type="checkbox"/>	<input type="checkbox"/>	_____

How many glasses of water do you drink daily? _____ Do you wear contacts? _____

Cleanser used _____

Moisturizer used _____

Specialty products used _____

Do you use essential oils on your skin? _____

SKIN TYPING

Circle the skin type that applies to you:

- I When in the sun for one hour without protection I always burn and never tan.
- II I always burn and sometimes tan.
- III I sometimes burn, sometimes tan.
- IV I never burn and always tan.
- V I am of non-black Hispanic, Asian, Mediterranean, or Middle Eastern ethnicity.
- VI I am of black Hispanic, African-American, or other African ethnicity.

Do you use tanning beds? _____ If yes, when was the last session? _____

Do you use tanning lotions? _____ If yes, when was last use? _____

When were you last exposed to the sun (tanning or working/playing outside)? _____

Do you have a vacation or sun exposure planned? _____ If yes, when? _____

GOALS AND EXPECTATIONS

How would you like to improve your skin? _____

What are your expectations? _____

Vein History

Family History

	Yes	No
Have you or any family members had a blood clotting problem?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or any of your family members had any unexplained blood clots?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or your family members had strokes, heart attacks, blood clots, or pulmonary emboli?	<input type="checkbox"/>	<input type="checkbox"/>
Do any of your family members have varicose veins?.....	<input type="checkbox"/>	<input type="checkbox"/>
How many children have you given birth to? _____		
What is your occupation? _____		

Vascular History

Indicate which of these problems you have had:

	Yes	No
Pain in your:	<input type="checkbox"/>	<input type="checkbox"/>
Thigh.....		
Calf.....	<input type="checkbox"/>	<input type="checkbox"/>
Entire leg.....	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of the legs.....	<input type="checkbox"/>	<input type="checkbox"/>
Skin or ulcer problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>

If you experience pain in your legs, please indicate the type of pain:

	Yes	No
Resting Pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Resting Cramps.....	<input type="checkbox"/>	<input type="checkbox"/>
Night Cramps.....	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness.....	<input type="checkbox"/>	<input type="checkbox"/>
Heaviness.....	<input type="checkbox"/>	<input type="checkbox"/>
Pain in specific area.....Please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>
Numbness.....	<input type="checkbox"/>	<input type="checkbox"/>
Burning sensation.....	<input type="checkbox"/>	<input type="checkbox"/>

Is the pain made worse by:

Extended periods of standing.....	<input type="checkbox"/>	<input type="checkbox"/>
Heat.....	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual periods.....	<input type="checkbox"/>	<input type="checkbox"/>
Exercising and/or walking.....	<input type="checkbox"/>	<input type="checkbox"/>
Medication.....	<input type="checkbox"/>	<input type="checkbox"/>

Is the pain improved by:

Elevation of the limbs.....	<input type="checkbox"/>	<input type="checkbox"/>
Elastic stockings.....	<input type="checkbox"/>	<input type="checkbox"/>
Walking and/or exercising.....	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever been treated for varicose veins with:

Sclerotherapy (injections).....	<input type="checkbox"/>	<input type="checkbox"/>
Laser therapy of spider veins.....	<input type="checkbox"/>	<input type="checkbox"/>
Closure.....	<input type="checkbox"/>	<input type="checkbox"/>
Surgery (vein stripping).....	<input type="checkbox"/>	<input type="checkbox"/>

Do you have or have you ever had:

	Right leg	Left leg	# of years
Varicose vein problems.....	<input type="checkbox"/>	<input type="checkbox"/>	
Phlebitis (redness and tenderness of a vein).....	<input type="checkbox"/>	<input type="checkbox"/>	
Blood clots.....	<input type="checkbox"/>	<input type="checkbox"/>	
Deep Vein Thrombosis (DVT).....	<input type="checkbox"/>	<input type="checkbox"/>	
Leg/hip fracture or joint replacement.....	<input type="checkbox"/>	<input type="checkbox"/>	
If you have ever been treated for any of these conditions, please explain:			
