

HUGHES CENTER FOR AESTHETIC MEDICINE
1765 S. SPRINGDALE ROAD, SUITE B-2
CHERRY HILL, NJ 08003

GENERAL PATIENT INFORMATION and SKIN CARE QUESTIONNAIRE

Today's date: _____

Name : _____ Date of Birth : _____ (Age) _____

Address : _____ Social Security #: _____

City/State/Zip : _____ Cell Phone : () _____

Home Phone : () _____ Business Phone: () _____

Occupation: _____ Spouses Occupation _____

Marital Status: M S D W Gender: Male Female Do you have children: Yes No

FULL Reason for your Consultation: _____

Who referred you to us : _____

Have you seen a dermatologist? Yes No

If yes, name and address: _____

Please list any previous COSMETIC SURGERY, Doctors Name: _____ None

Medications & Dosage: (Include over the counter medication) None or please list: _____

Drug Allergies (Please list allergic reaction): _____

Have you ever had: Hepatitis B: Yes No Hepatitis C: Yes No HIV: Yes No

Do you suntan? Yes No Do you use sunscreen? Yes No

Please name the brand of products you are currently using:

Cleanser _____ Toner _____ Scrub _____

Moisturizer _____ Mask _____ Other _____

Have you ever used Retin-A? Yes No If yes, what strength

? _____

Have you ever been treated with Phenol or Trichloroacetic? Yes No

Have you ever used Hydroquinone? Yes No

Have you ever been on Accutane? Yes No If yes, when ? _____

Have you ever had herpes, hives, cold sores, fever blisters or keloids? Circle if any apply

If yes to any of the above, please state when and describe : _____

Would you characterize you skin as: Sensitive Tough Dry Oily

If you had any complaints about your skin, what would it be? _____

Describe your skin in three words : _____

Any additional comments? _____

Do you smoke? Yes No If yes, how many per day? _____

In Case of Emergency (REQUIRED):

1. Name: _____ Relationship: _____

Address & Telephone: _____

Do we have your permission to leave a message on your answering machine and/or with family members?

_____ **yes** _____ **no PLEASE SIGN:** _____