

Treatment by \_\_\_\_\_

Telemed by \_\_\_\_\_

Assisted by \_\_\_\_\_



OSKIN CARE LLC  
OSKIN MEDICAL CORP.

## CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire.  
All information is strictly confidential.

### PATIENT CONTACT INFORMATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Email \_\_\_\_\_

Driver's Lic # \_\_\_\_\_ Referral \_\_\_\_\_ Occupation \_\_\_\_\_

### MEDICAL HISTORY

Are you currently under the care of a physician?  Yes  No

If yes, for what: \_\_\_\_\_

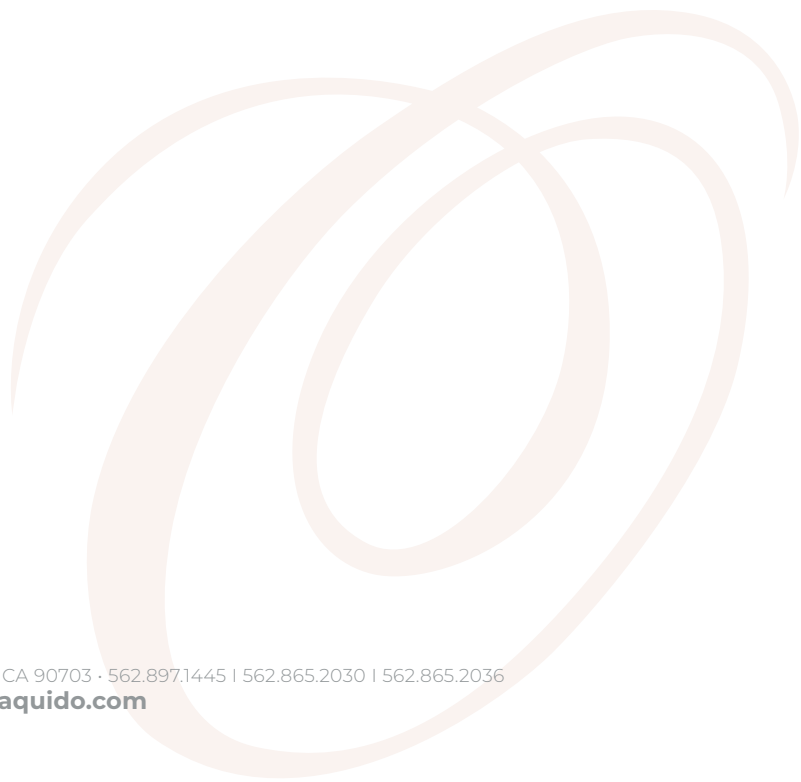
Do you have any of the following medical conditions? (Please check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arthritis                   |
| <input type="checkbox"/> Frequent cold sores    | <input type="checkbox"/> HIV / AIDS          | <input type="checkbox"/> Skin disease / Skin lesions |
| <input type="checkbox"/> Seizure disorder       | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Thyroid imbalance           |
| <input type="checkbox"/> Blood clotting         | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Hormone imbalance           |
| <input type="checkbox"/> Abnormalities          | <input type="checkbox"/> Infection           | <input type="checkbox"/> Diabetes                    |
| <input type="checkbox"/> Keloid scarring Active | <input type="checkbox"/> Other _____         |  |

Do you have any other health problems or medical conditions? Please list: \_\_\_\_\_

Have you ever had an allergic reaction ? ( Please check and list any and all that you have had and describe the reaction you experienced )

- |   |   |
|---|---|
| <input type="checkbox"/> Vegetable Protein (Nuts, Seeds, Soy)                                   | <input type="checkbox"/> Hydrocortisone |
| <input type="checkbox"/> Animal Protein (eggs, meat, chicken, poultry, seafood, dairy products) | <input type="checkbox"/> Other _____    |
| <input type="checkbox"/> Aspirin  | _____                                   |
| <input type="checkbox"/> Lidocaine  | _____                                   |
| <input type="checkbox"/> Hydroquinone or skin bleaching agents                                  | _____                                   |





## MEDICATIONS

Do not leave any field blank. Please mark as "NA" if not applicable.

Birth control pills (Female only)     Hormones     Others (It is required that you list all of them): \_\_\_\_\_

\_\_\_\_\_

What antibiotics do you use to treat infections? \_\_\_\_\_

\_\_\_\_\_

Do you take any medications for heart conditions?     Yes     No

If yes, please indicate: \_\_\_\_\_

\_\_\_\_\_

Are you on any mood altering or anti-depression medication?     Yes     No

If yes, please indicate: \_\_\_\_\_

\_\_\_\_\_

What topical medications or creams are you currently using? \_\_\_\_\_

Retin-A/Tretinoin     Hydroquinone     Hydrocortizone     Others (Please list): \_\_\_\_\_

\_\_\_\_\_

What herbal supplements do you use regularly? \_\_\_\_\_

## HISTORY

FOR OUR FEMALE CLIENTS:

Are you pregnant or trying to become pregnant?     Yes     No

Are you breastfeeding?     Yes     No

Are you using contraception?     Yes     No

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

SIGNATURE OF PATIENT/GARDIAN

DATE

## FOR OFFICE USE ONLY

HEALTH CARE PROFESSIONAL SIGNATURE

DATE

PRINT NAME/TITLE

PATIENT NAME