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)

- ☐ Cancer
- ☐ Frequent cold sores
- ☐ Seizure disorder
- ☐ Blood clotting
- ☐ Abnormalities
- ☐ Keloid scarring Active
- ☐ High blood pressure
- ☐ HIV / AIDS
- ☐ Hepatitis
- ☐ Herpes
- ☐ Infection
- ☐ Arthritis
- ☐ Skin disease / Skin lesions
- ☐ Thyroid imbalance
- ☐ Hormone imbalance
- ☐ Diabetes
- ☐ 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)

- ☐ Vegtable Protein (Nuts, Seeds, Soy)
- ☐ Animal Protein (eggs, meat, chicken, poultry, seafood, dairy products)
- ☐ Aspirin
- ☐ Lidocaine
- ☐ Hydroquinone or skin bleaching agents
- ☐ Hydrocortisone
- ☐ Other

_____

_____

_____

_____

OSKIN MED SPA

CERRITOS MALL · 369 Los Cerritos Center, Cerritos, CA 90703 · 562.897.1445 I 562.865.2030 I 562.865.2036
www.oliviaquido.com

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