PREMIER GENOMICS
PremierFIT

SKIN PANEL TEST REQUISTION

Aging & Appearance, Inflammation & Allergies, Health & Wellness

PATIENT INFORMATION

Sample Collection Date (MM/DD/YYYY):	Patient Name (Last, First):		Date of Birth:
Street Address:	City, State, Zip:	Contact #:	Sex: ☐ Female ☐ Male

BACKGROUND

CHECK ALL THAT APPLY	
African American/Black	☐
American Indian	☐
Asian	☐
Caucasian	☐
Hispanic/Latino	☐
Pacific Islander	☐
Other (list):	☐

MEDICAL HISTORY

CHECK ALL THAT APPLY		ADDITIONAL	
Diabetes	☐	Height:	
Arthritis	☐	Weight:	
Asthma	☐		
Skin Conditions	☐	Please specify.:	
High Blood Pressure	☐		
Bone or Muscle Conditions	☐	Please specify.	
Occupational Exposure to Metals	☐	Which Metals?	

Patient Signature: Date:

ORDERING PHYSICIAN AND/OR OTHER LICENSED MEDICAL PROFESSIONAL

Name (Last, First):	Facility Name:	
Street Address:	City, State, Zip:	
Phone:	Fax:	Email:

CONFIRMATION OF INFORMED CONSENT

By ordering testing, the undersigned person represents that he/she is a licensed medical professional authorized to order genetic testing OR is a representative of a licensed medical professional authorized to order testing.

Medical Professional Signature: Date:

QUESTIONNAIRE

What is your eye color? ☐ Brown ☐ Blue ☐ Blue/Green ☐ Hazel ☐ Non-pigmented ☐ Other _____

What is your natural hair color now? ☐ Blonde ☐ Light Brown ☐ Dark Brown ☐ Black ☐ Red ☐ Salt/Pepper ☐ Silver ☐ White, Non-pigmented

What was your natural hair color as a child? ☐ Blonde ☐ Light Brown ☐ Dark Brown ☐ Black ☐ Red ☐ Non-pigmented

Do you dye your hair? ☐ No ☐ Yes How often? _____

How often are you exposed to direct ultraviolet (UV) light from sun for more than 20 min?
☐ Less than once a week ☐ Once a week ☐ 2-3 times a week ☐ Almost everyday

How much alcohol do you consume? ☐ None ☐ 1-2 drinks per day/week/month ☐ 3-4 drinks per day/week/month
☐ 5 or more drinks per day/week/month

Have you ever smoked? ☐ No ☐ Yes ☐ Current smoker ☐ Past smoker
At what age did you begin smoking? _____ How many packs/day? _____ How many years? _____

Do you drink coffee or caffeinated beverages? ☐ No ☐ Yes, How often? _____

Are you currently taking prescribed medication? ☐ No ☐ Yes, Medication(s): _____

Do you have allergies? ☐ No ☐ Yes, Allergy(s): _____

What is your skin type? ☐ Fair: always burn, do not tan ☐ Medium-Fair: easily burn, rarely tan ☐ Medium: sometimes burn, sometimes tan
☐ Medium-Dark: less likely to burn, tan easily ☐ Dark: tan easily, rarely burn ☐ Very Dark: do not burn