

Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Contact Order: (ie: Home, Cell, Work) 1st _____ 2nd _____ 3rd _____

Email Address: _____

May we contact you by email? No ___ Yes ___ General Email Communications Email Newsletter/Promotions

Any restrictions for contacting you? No ___ Yes ___ If yes, please list _____

Date of Birth: _____ Gender: Female _____ Male _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Number (s): _____

How did you hear about us? _____ (or) Who may we thank for referring you? _____

General appearance or products of interest to you (please check all that apply).

<input type="checkbox"/> Skin care advice and products	<input type="checkbox"/> Unwanted hair	<input type="checkbox"/> BOTOX® Cosmetic or Juvederm
<input type="checkbox"/> Blotchy skin	<input type="checkbox"/> Thin lips	<input type="checkbox"/> Chemical Peel/Microdermabrasion
<input type="checkbox"/> Sun/brown/age spots	<input type="checkbox"/> Facial folds	<input type="checkbox"/> Laser Hair Removal
<input type="checkbox"/> Facial /Neck /Chest Redness	<input type="checkbox"/> Skin laxity or sagging	<input type="checkbox"/> IPL PhotoRejuvenation
<input type="checkbox"/> Facial fine lines and wrinkles	<input type="checkbox"/> Excessive perspiration/sweating	<input type="checkbox"/> Laser Skin Tightening
<input type="checkbox"/> Acne scars / Large pores	<input type="checkbox"/> Menopausal Symptoms	<input type="checkbox"/> LipoDissolve Contouring
<input type="checkbox"/> Active acne	<input type="checkbox"/> Other _____	<input type="checkbox"/> Bioidentical Hormone Replacement

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

<i>Younger Than</i>		<i>True Age</i>		<i>Older Than</i>
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about my appearance.

<i>Not Concerned</i>		<i>Somewhat Concerned</i>		<i>Very Concerned</i>
1	2	3	4	5

Client Health & Skin Care History

1. Medications (prescription, over the counter, vitamins, herbal) _____

2. Allergies: (Circle all that apply) Milk, apples, citrus, grapes, aloe vera, aspirin, hydroquinone, latex ?

Any other allergies? No ___ Yes ___ If yes, what? _____

3. Surgeries (including plastic surgery) _____

4. Medical Conditions / History of (Check all that apply):

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Neuro-muscular Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Disease | <input type="checkbox"/> Auto-Immune Disorders | <input type="checkbox"/> Bleeding/Clotting Problems |
| <input type="checkbox"/> Cold Sores / Fever Blisters | <input type="checkbox"/> Other _____ | | |

Patient Name: _____

5. Are you pregnant? Yes / No Breastfeeding? Yes / No
6. Do you smoke? Yes / No Amount Daily _____ Do you drink? Yes / No Amount Daily _____
7. List skin care products/make-up you currently use: _____
-
8. In the past 3 months have you used: Retin-A, Renova, Differin, Accutane, Antibiotics (oral or topical)?
If so, for how long? _____
9. Describe your skin (Circle all that apply): Normal Oily Dry Combination Acne
 Uneven/Blotchy Mature Wrinkled Large pores Rosacea
10. Have you had: electrolysis waxing laser hair removal laser vein removal sclerotherapy?
11. Have you ever had dermal fillers/implants (i.e. Collagen, ArteFill, Radiesse, Restylane, Perlane, Silicone, etc) in the areas you are considering having treatment? Yes _____ No _____
12. Have you had any cosmetic peels? Yes _____ No _____ If yes, what type and when? TCA _____
 Glycolic/AHA _____ Laser _____ Phenol _____ Other _____
15. Ethnicity (Check all that apply): Caucasian Hispanic / Latino Black Mediterranean
 Indian East Indian Asian Other _____

SKIN TYPE WORKSHEET

Score	Analysis	0	1	2	3	4
	What color are your eyes?	Light Blue, Grey or Green	Blue, Grey or Green	Blue	Dark Brown	Brownish Black
	What is your natural hair color?	Sandy Red	Blond	Chestnut, Dark Blond	Dark Brown	Black
	What is the color of your skin? (unexposed areas)	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful, redness, Blistering, Peeling	Blistering followed by Peeling	Burns, sometimes followed by peeling	Rarely Burns	Never had Burns
	To what degree do you turn brown?	Hardly or not at all	Light Color Tan	Reasonable Tan	Tan very easily	Turn Dark Brown Quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very Sensitive	Sensitive	Normal	Very Resistant	Never had a problem
	When did you last expose yourself to the sun, tanning bed, or self-tanning creams?	More than 3 Months Ago	2-3 Months Ago	1-2 Months Ago	Less than 1 Month Ago	Less than 2 Weeks Ago
	Do you expose the area to be treated to the sun?	Never	Hardly Ever	Sometimes	Often	Always
	Fitzpatrick Skin Type:					
Total Score	I (0 -7) II (8 - 16) III (17 - 25) IV (26 - 30) V-VI (over30)					

The above information is true and accurate to the best of my knowledge.

Patient Signature: _____

Date: _____