Reflections Aesthetic and Laser Solutions

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772-567-7196 www.Reflectionsals.com

Apollo Skin Tightening • Hair & Vein Removal • Sun Spot Removal • Dermal Filler • Botox • Skin Care

Name____ Today's Date _____/_____/_____
Last First Mo Day Yr
Address:____ Birthdate _____/_____/_____
Mo Day Yr
City:__________________________________ State:___________________________ ZIP:________________

Best phone number to contact you regarding your treatment and where we may leave a message:

Home Phone:( ) _______________Cell Phone:( ) _______________Work Phone:( ) _______________

E-mail ___________________________________ How did you hear about us? _________________________

Primary Care Physician _______________________________

Please tell us your main concerns that brought you to our office today: ________________________________

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This information is necessary for your procedure. Please answer yes or no to the following questions:

YES	NO	
❑	❑	Are you using any prescribed medications? List____
❑	❑	Are you using any Herbal medications? List____
❑	❑	Do you take oral anti-coagulant (blood thinning) medication? List __________________________
❑	❑	Are you allergic to any cosmetic ingredients, medications or foods? List _____________________ ____
❑	❑	Are you pregnant or trying to become pregnant?
❑	❑	Do you use oral contraceptives?
❑	❑	Do you use hormone replacement therapy?
❑	❑	Do you smoke? How much? _____________ How long?_____________
❑	❑	Do you spend a lot of time outdoors or use a tanning bed often?
❑	❑	Do you have any tattoos or permanent makeup?

Please check any health problems, past or present:

❑ Seizures ❑ Liver disease ❑ Skin cancer (Type: _____________)
❑ Hormonal Problems ❑ Diabetes ❑ Cystic Acne ❑ Thyroid ❑ Cancer
❑ High Blood Pressure ❑ Heart problems ❑ Collagen (Lupus, ❑ Sarcoidosis ❑ Hepatitis
❑ Vasovagal Syncope ❑ PCOS ❑ Autoimmune (lupus, scleroderma) ❑ Asthma
❑ Other:____

Do you have any of the following chronic skin disorders?

❑ Psoriasis ❑ Dermatitis ❑ Eczema ❑ Keloid Scarring
❑ Fever Blisters ❑ Cold Sores ❑ Sun Blisters ❑ Herpes Simplex/Blisters

❑ Other: _________________________

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In addition to the above, please tell us which skin conditions concern you the most (Check all that apply):

❑ Uneven skin tone ❑ Visible exposed blood vessels ❑ Hard bumps under skin
❑ Enlarged pores ❑ Clogged pores ❑ Blackheads /Whiteheads
❑ Acne ❑ Excessive oiliness ❑ Pimples
❑ Upper lip lines ❑ Wrinkles ❑ Scarring
❑ Sun Spots ❑ Dry patches ❑ Unwanted Hair
❑ Sun Damage ❑ Brown spots (Hyperpigmentation) ❑ White spots (Hypopigmentation)

What is your skin type: ❑ Dry ❑ Combination ❑ Oily ❑ Normal

Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation?

Please list____
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Have you ever had any of the following wrinkle fillers or implants:

❑ Collagen ❑ Restylane ❑ Perlane ❑ Hylaform ❑ Juvaderm ❑ Silicone ❑Radiesse
❑ Sculptra ❑ Belotero ❑Other:_______________________________

* If so, when? _________________What area? ____________________________By whom? ____________________

Have you ever undergone any of the following treatments?

❑ Cosmetic Surgery What area of the body? ____
When and where was it done? ____
❑ Botox What area of the face? ____
When and where was it done? ____

❑ Acid Peel ❑ Accutane ❑ Microdermabrasion ❑ Lasers Which one? _____________________

When and where was it done? ____

Are you currently removing hair by any of the following methods?

❑ Waxing ❑ Tweezing ❑ “Nair” type products ❑ Electrolysis ❑ Laser Hair Removal

*If so, when?_______________What area?___________________________What type of laser?___________________

I certify that the above information is correct to the best of my knowledge. _________________________
Patient’s Signature

Reflections Notes:
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