Patient Information

Patient Name:_____ Date_____

Date of Birth:_____ Age:_____ Race:_____ Occupation _____

Address: _____ City:_____

State _____

Zip Code:_____ Cell Phone:_____ Work Phone _____

Email Address_____

How did you hear about our office? _____

Name of person who referred you, if applicable _____

What conditions/treatments of interest (check all that apply)

___ sun spots
___ wrinkles
___ melasma
___ acne/acne scarring
___ dry skin
___ facial redness
___ skin laxity
___ laser hair reduction
___ eye lash serum
___ Botox
___ Dermal Fillers
___ textural issues/Laser Resurfacing
___ dull complextion
___ medical grade skin care

List you top three concerns that you would like to see improved in order of importance:

1. _____

2. _____

3. _____

How much time do you spend in the sun/tanning bed? _____

Do you wear sunscreen? _____ How often_____SPF/brand _____

How would you describe your skin? _____

Have you ever had any non-surgical aesthetic treatments? (laser, botox, dermal filler, chemical peel, radiofrequency,) ❑ yes ❑ no

If so please list: _____

Amount of water you drink in a day? _____ Pregnant or breastfeeding? _____

How much downtime and/or time off work can you devote to recovery?

❑ None ❑ 1-2 days ❑ 3-5 days ❑ 5-7 days

Medical History

Do you have or have ever had any of the following:

_____ history of Keloid scarring
_____ bruise easily
_____ history of cold sores
_____ skin cancer
_____ pacemaker/defibrillator
_____ skin disorders

_____ Accutane (past 6 months)
_____ endocrine/Hormonal disorder
_____ pigmentation Disorder
_____ AIDS/HIV
_____ Rosacea
_____ blood clotting/bleeding abnormalities
_____ high blood pressure
_____ seizures
_____ heart problems high blood pressure
_____ autoimmune disease
_____ connective tissue disease such as Lupus or Scleroderma

Any other health conditions not listed above: _____

Drug allergies: _____

Please list all your medication, including over the counter medications:

_____

_____

_____

Do you currently take any of the following medication:

___ Accutane
___ Vitamin E
___ Aspirin
___ Ibuprofen
___ Advil
___ Herbals
___ Retin-A
___ Steroids
___ blood thinners
___ Immunosuppresants
___ pain patch

History of any cosmetic or medical surgeries? Please list:

_____

_____

I have answered the above questions truthfully and will notify you of any changes in medications and physical conditions

Patient Signature_____ Date: _____