New Patient Intake Form

Name: ______________________________ Date of Birth: ______________

Street Address: ____

City: ______________________________ State: __________ Zip: ______________

Home Ph #: ______________ Cell Ph #: ______________ Work Ph #: ______________

Email: ______________________________ Occupation: ______________________________

Emergency Contact: ______________________________ Phone Number: ______________________

How did you hear about us? ______________________________ Referred By: ______________________

SKIN CARE

Which of the following best describes your skin type?

☐ Very Oily Skin ☐ Large Pores ☐ Acne ☐ Dry Skin ☐ Sensitive ☐ Combination ☐ Normal

Are you currently using any medical grade skin care products? ______________________________

What is your daily skin care regimen? ____

____

How would you rate the overall quality of your skin?

☐ Poor ☐ Fair ☐ Good ☐ Very Good

Are you currently using any topical medication (like Retin-A®) or exfoliating acids like salicylic or glycolic?

☐ Yes ☐ No If yes, explain: ____

Are you currently using or have you used Accutane® in the past 12 months? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No Are you wearing them right now? ☐ Yes ☐ No

What improvements would you like to see to your skin? ______________________________

____

SUN HISTORY AND LIFESTYLE

How often do you work outdoors? ☐ Frequently ☐ Occasionally ☐ Rarely

How often do you use sunscreen? ☐ Frequently ☐ Occasionally ☐ Rarely

How often do you tan or wear self-tanner? ☐ Frequently ☐ Occasionally ☐ Rarely

New Patient Intake Form

MEDICAL HISTORY AND ALLERGIES

Please list all current medications, prescriptions, and homeopathic supplements: ______________________

____

____

Please list all allergies: ____

____

____

Have you had any vaccines in the last 2 weeks? ☐ Yes ☐ No

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

- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐
- ☐ HIV or Other Immune Deficiency Disorders
- ☐ Epilepsy / Seizure Disorders
- ☐ Liver Disease
- ☐ Hormone Imbalance
- ☐ Herpes/Cold Sores
- ☐ Hepatitis
- ☐ Skin Disorder

PREVIOUS PROCEDURES

Which of the following have you had in the last three months?

- ☐ BOTOX®
- ☐ Dysport®
- ☐ Xeomin®
- ☐ Fillers/JUVÉDERM®
- ☐ Radiesse®
- ☐ Restylane®
- ☐ Voluma®
- ☐ Microdermabrasion
- ☐ Chemical Peels
- ☐ Laser Hair Removal
- ☐ Permanent Makeup
- ☐ Skin Resurfacing
- ☐ Skin Rejuvenation
- ☐ Skin Tightening
- ☐ Facial Plastic/Reconstruction Surgery
- ☐ Other

WOMEN ONLY: Are you pregnant or breastfeeding? ☐ Yes ☐ No

Are you interested in learning more about any of the following?

- ☐ Mirodermabrasion
- ☐ FIller
- ☐ Chemical Peels
- ☐ Laser IPL
- ☐ PRP
- ☐ Specials / Packages
- ☐ Plastic Surgery
- ☐ Weight Loss
- ☐ Tattoo Removal
- ☐ BioTE (Hormone Replacement Therapy)
- ☐ Other

Patient Signature: ________________________________ **Date:** ______________

Staff Signature: ________________________________ **Date:** ______________

Patient Interest Questionnaire

Patient Name: ______________________________

Date: ____________________ Date of Birth: ____________________

PLEASE INDICATE ANY AREA OF CONCERN FOR YOU. CHECK ALL THAT APPLY

- ☐ Forehead Lines
- ☐ Lip appearance and texture
- ☐ Frown Lines
- ☐ Thin Lips
- ☐ Crow's Feet Lines
- ☐ Double Chin
- ☐ Flattened/ Sunken Cheeks
- ☐ Thinning or inadequate lashes
- ☐ Lines and wrinkles around the nose and mouth
- ☐ Skin appearance and texture

BE SURE TO BRING THIS TO YOUR AESTHETIC SPECIALIST FOR YOUR ASSESSMENT