

PATIENT INFORMATION

Date Patient Name

Address, City, State, Zip

Home Phone Cell Phone Work Phone

Email Address:

Birth Date Age Place of Employment

Please Circle One*:* Married / Single Please Circle One*:* Female / Male

May we leave detailed messages for you?*:* Cell Phone / Email / Both

Reason for Visit Referred By

Emergency Contact Name, Relationship, and Phone Number

*Please explain any of the following that may apply:*

Heart Condition Keloids

Diabetes Cold Sores/Herpes

Permanent Tattoos

# Do you smoke? Yes No

# Do you exercise? Yes No

Have you been on Accutane in the past 6 months? Yes No

Are you using Retin A, Glycolic, or Lactic Acid? Yes No

Please list any other medications that may make you photo sensitive:

Please list all medication you are currently taking (blood thinners, antibiotics, herbs, supplements, vitamins, aspirin, etc.):

Please list any facial/skin products and brands that you are currently using:

Please list all allergies:

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

Kidney disease Yes No

Hepatitis Yes No

Severe depression Yes No

Needle phobia Yes No

Skin disease Yes No

Bleeding disorder Yes No

Recent stroke Yes No

Fainting/Dizzy spells Yes No

If you answered yes to any of the above, please explain:

Do you currently experience or have ever experience any of the following:

Breakouts Yes No

If yes, what frequency? Rarely, Sometimes, Often

Cystic breakouts Yes No

Scarring as a result of acne Yes No

Blackheads Yes No

Clogged pores Yes No

Hard bumps under the skin Yes No

Excessive oiliness Yes No

Dry patches Yes No

**Skin History:**

Have you had prolonged sun exposure, either outside or in a tanning bed, in the last three days? Yes No

If yes, are you currently sunburned? Yes No

Do you use tanning beds? Yes No

Do you use chemical tanning products? Yes No

Do you use sunblock on a regular basis? Yes No

When your skin is exposed to the sun for approximately one hour with no protection, how do you typically respond? *Please circle one.*

1. Always burns, never tans
2. Usually burns, tans with difficulty
3. Sometimes burns mildly, gradually tans
4. Rarely burns, tans with ease
5. Very rarely burns, tans very easily
6. Never burns, tans very easily

What is your ethnicity? *Please circle one.*Caucasian Mediterranean Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Asian African AmericanHispanic Native American

**Female Patients:**

Do you have permanent makeup? Yes No

Are you pregnant? Yes No

Are you breastfeeding? Yes No

Do you take oral contraceptives? Yes No

Do you take hormone medication? Yes No

Do you have excessive hair on your face and/or breasts? Yes No

Have you ever had facial hair removed? Yes No

Method of facial hair removal Date of last facial hair removal treatment

Date of last menstrual period

Have you ever had any service(s) similar to the ones we offer? If yes, please list date of last treatment and explain:

Is there anything else about you or your medical history that has not been addressed or explained? The more information we have about you, the better we can address your specific skincare questions and concerns.

**\*I certify that the above information and medical history is complete and accurate.\***

X

Signature of Patient *or Person Authorized to Sign for Patient*

X

Printed Name of Patient *or Person Authorized to Sign for Patient*

X

Date