

Aesthetic Patient Intake Forms

Personal Information	
Name	Home Phone
Address	Work / Mobile Phone
City	Prov / State
Zip Code	Date of Birth
Referred by	Sex: ___ Male ___ Female

Email Address: _____

Prior Aesthetic Treatments

Treatment Type	Last Treatment	Treatment Location
Laser Hair Removal	_____	_____
Laser Vein Removal	_____	_____
IPL for pigment or redness	_____	_____
CO2 or Fractional Laser	_____	_____
Microdermabrasion or Peel	_____	_____
Botox or Dysport	_____	_____
Dermal Fillers	_____	_____
Cosmetic Surgery Type	_____	_____

Past Medical History

Diabetes	Yes	No
Tattoos	Yes	No
Skin Cancer	Yes	No
Other Cancer	Yes	No
Heart trouble	Yes	No
Difficulty Healing	Yes	No
Bleeding tendency	Yes	No
Seizure Disorder	Yes	No
Neuromuscular Disorders	Yes	No

Current Medications

Allergies

Social History

Marital Status: _____

Alcohol?: Never Rarely
 Socially Daily

Tobacco? Never
 Previously, but quit
 Currently

Drugs? Never
 Currently

Type _____

Pregnant or Nursing? Yes No

Hobbies: _____

Occupation: _____

Sun Exposure: _____

Fitzpatrick Skin Type

(To be completed by staff)

I II III IV V VI

MEDICAL HISTORY

Name _____ E-mail _____
 Address _____ Apt. _____
 City _____ State _____ Zip Code _____
 Birthdate _____ Home Phone () _____ Cell Phone () _____
 Employer _____ Work Phone () _____
 Referred by _____

Past Surgeries (last 10 years) **Date**

Medications (prescription and over the counter: vitamins, herbs, supplements, anti-inflammatory)

Medication Allergies **Allergic Reaction**

Medical History: Circle all that apply

Acne	Arthritis	Asthma	Bleeding disorder
Blood clots	Burns/skin grafts	Cancer	Diabetes
Drug abuse	Endocrine disorders	Epidermolysis Bullosa	Gold therapy
Cold sores/Herpes	Hepatitis	Auto immune disease	Heart disease
High blood pressure	Hirsutism	Hormone replacement	Implants
Kidney Disease	Keloid scars	Lung Problems	Lupus
Permanent makeup	Precocious puberty	Polycystic Ovary disease	Rosacea
Bells Palsey	HIV/AIDS	Port wine stain	Psoriasis
Psychiatric treatment	Seizures	Shingles	Skin cancer
Stroke	Tattoos	Thyroid disease	Ulcers
Varicose veins	Vitiligo	Rheumatoid arthritis	Nerve disorder

- Please answer yes/no to the following questions:**
1. Are you currently being treated for any medical condition yes no
 Explain: _____
 2. Have you had any adverse reactions from facial injections in the past yes no
 If yes, what was the reaction _____
 3. Have you used Accutane in the past 12 months? How recent _____ yes no
 4. Do you have any active skin disease or infections? yes no
 5. Do you have any skin allergies? yes no
 6. Are you allergic to Latex, lidocaine or lotions? yes no
 7. Are you currently using glycolic acid or Retin-A? yes no
 8. Have you had a chemical peel or facial within the last week? yes no
 9. What products are you currently using on your skin? _____
10. Have you had any permanent cosmetic tattooing? yes no
 11. Do you have any synthetic or metal implants? Location? yes no
 12. Have you had any previous laser treatment or other skin treatment yes no
 13. Are there any moles with hair in the area to be treated yes no
 14. Are you currently using or have you used in the last 6 weeks a tanning bed or tanning creams? Date of last use ____/____/____ yes no
 15. Have you been exposed to the sun within the last 4-6 weeks? yes no
 16. Females: Are you pregnant? Yes no If yes, are you breastfeeding? yes no
 17. Are you planning to become pregnant within a year? yes no

I confirm that the answers to the questions are true and correct. I also confirm that the consultant clarified any questions I did not understand.

Signature of patient _____ **Aesthetic Care Provider** _____
Date _____ **Date** _____