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**_____