Patient Information

Date: ______________________

Name: ____

Address: ____

City: _____________________ State: _________________ Zip: ______________

Home Phone: ______________________ Work Phone: _______________________

Cell Phone :________________________ Email: ___________________________

Employer: _________________________ Occupation: _______________________

Birthdate: ____/____/____ Age: _____ Sex: Female _____ Male _____

Emergency Contact Name: ____

Phone: ________________________ Relationship: ___________________________

How did you hear about us? __________________________

Did a friend/relative refer you? If so: Name: ____

May we thank them for the referral? Yes____ No____

HISTORY:

Are you allergic/reactive to any medications, products, or skin care ingredients?

If so, please list: ____

Do you currently have, or have a history of any medical conditions (diabetes, thyroid disorder, hormone imbalance, high blood pressure, hepatitis, skin cancer, heart problems, vitiligo, coagulopathies, wound infections, keloids, or hypertrophic scarring?

If so, please list: ____

Are you pregnant or nursing? Yes_____ No______

Do you have a history of Herpes? Yes____ No______ Last Outbreak If so: _________

Have you had Gold Therapy, for Rheumatoid Arthritis? Yes____ No_____

If so when? ____

Have you had a recent surgery? Yes____ No____

If so when? ____

List any medications, vitamins, or other nutritional supplements/herbs that you take on a regular or on an occasional basis (including aspirin):____

Have you recently used any special creams or medications to treat a skin condition?

If so, please list: ____

Do you experience big mood swings in your mood or suffer from depression or anxiety?
Yes____ No____

Do you have permanent makeup or tattoos? Yes____ No____ If so what areas?

____

Do you smoke? Y/N

Exercise regularly? Y/N

Wear Contacts? Y/N

Do you take diet pills? Y/N

Do you drink caffeinated beverages? Y/N – If yes how much daily?______________

Do you regularly use a sunscreen on your skin? Y/N – If yes, usual SPF___________

How many alcoholic beverages do you consume? __daily __ weekly __ monthly __ rarely

Have a pacemaker or defibrillator? Y/N

Have implants or metal implants? Y/N

Do you take diuretics or laxatives? Y/N

How much water do you drink daily? ____

Do you have ___oily ___ dry ___ or ___ acne-prone skin?

Skin type, or when exposed to the sun WITHOUT PROTECTION for approx. one hour:

___I Always burns, never tans

___II Always burns, sometimes tans

___III Sometimes burns, sometimes tans

___IV Always tans

___V Hispanic __ Mediterranean __ Middle Eastern

___VI Black

What is your national origin? _________________________

Do you have any Native American in your family history? Y/N

Do you have any Italian in your family history? Y/N

Do you blush easily when nervous? Y/N Do you often experience facial redness/flushing? Y/N

Do you use self-tanning lotions? Y/N Most recent use: ___________________________________

Do you use a tanning bed? Y/N Most recent use: ____

When was your last significant exposure to the sun with little or no sunscreen?

____

Are you planning a holiday in the sun? Y/N If so when? ______________________________

What methods do you or have you used for hair removal? __ shaving __ electrolysis

__ tweezing __ waxing __ bleaching __ creams (Nair) __

Prior treatment with Intense Pulse Light? Y/N If so when? ____________________________

Have you had a chemical peel? Y/N What type? __________ Most recent? ________

Have you had a microdermabrasion? Y/N Most recent? ______________________

Previous Botox? Y/N Most recent? ___________ Area treated? _______________

Previous Collagen? Y/N Most recent? _________ Area treated? _______________

Do you experience skin breakouts? Y/N Can you relate it to any cause? ____________________

Do you ever experience these conditions on your skin? __ oily __ tightness __ dryness

What type of skin care products are you currently using? __________________________

bar soap __ cleanser __ toner __ masque __ moisturizer __ scrub/peel __ other___________

Do you have any other issues or questions that you would like us to address today? Please specify:

____

What are your expectations from your treatment here? ___________________________

____

____

Can we take your photos for your files? ____ Yes ____ No

Thank you.....This information is completely confidential, and will be used only to help us give you the best care possible.