Patient Intake Form

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Name ______________________________ Today's Date __________

Date of Birth __________ Age ______ Occupation ______________________

Address ____

City ______________________ State __________ Zip Code __________

Home Phone ____________________ Work Phone ____________________

Emergency Contact Name and Phone ______________________________

How were you referred to us? __________________________________

If friend/relative, who may we thank for the referral ______________________

Do you regularly sunbathe or use tanning salons? ________ How often? ________

Which of the following aesthetic treatments have you had in the past?

Facials Botox Filler (Juvaderm/Restalyne/Radiesse/Voluma)

Skin Tightening Chemical Peels Microneedling

Threads Laser Treatments Facial Plastic Surgery

What have you tried for hair loss? Biotin Rogain Propecia

MEDICAL HISTORY

Are you pregnant? Yes No Are you breastfeeding? Yes No

Are you planning on becoming pregnant? Yes No

Do you have any of the following **medical conditions**? (Please circle all that apply)

Anemia	Fibromyalgia
Arthritis	Heart Disease
Autoimmune Disorder	Herpes Simplex
Bleeding Disorder	Hepatitis B or C
Blood Clots	High Blood Pressure
Breast Cancer	HIV/AIDS
Burns	Migraines
Cancer	Multiple Sclerosis
Cold Sores	Seizures
Diabetes	Thyroid Disorder

Other: ____

Do you have any of the following **skin conditions**? (Please circle all that apply)

Skin disease/Skin lesions	Melanoma
Shingles	Skin cancer
Lupus	Keloid Scarring

Do you have any other health problems or medical conditions? Please list:

____

____

Please list all prior **surgical procedures** ______________________________

____

Please list all **medications/supplements** ______________________________

____

Allergies: (List any and all that you have had and describe the reaction you experienced)

Latex	Aspirin
Animal Protein	Lidocaine
Hydrocortisone	Penicillin

Other ____

____

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature ________________________________ Date: ______________