Patient Profile

Patient Name:____ Date:_____________________

Date of birth:____ Age______ Sex: □ Male □ Female

Street Address:____

City:_________________________ State:______________ Zip:_______________________________

Home Phone:________________________ Cell:____

Work Phone:________________________ E-mail:____

May we call you at home?:□ Yes □ No May we call you at work?:□ Yes □ No

May we e-mail you?:□ Yes □ No Emergency Contact and Phone:______________________

How did you hear about us?:____

Patient History:

Pharmacy:______________________________ Primary Physician:____________________________

Reason for visit:____

Medical History: (Check all that apply):

□ AIDS/ARC □ Allergy/hay fever □ Dizziness/fainting spells □ Epilepsy

□ Skin rash/disease □ Asthma or wheezing □ Head injury □ Eye injury

□ Heart trouble □ Shortness of breath □ Neuritis □ Swollen joints

□ Cancer □ Tuberculosis □ Mitral valve prolapsed □ Arthritis

□ Diabetes □ Varicose veins □ Drug or alcohol addiction □ Tendonitis

□ High blood pressure □ Phlebitis of vein □ frequent severe headaches

□ Bone or joint deformity □ Bleeding Problems □ Back problem/pain

Name:___________________________________Date of Birth_____________Date__________

□Nervousness □Ankle/feet swelling

Last apt with dermatologist:_______________________

List other diseases or illnesses you have had:

____

____

Are you or could you be pregnant? ☐Yes ☐No

Do you have a history of Herpes I or II in the area to be treated? ☐Yes ☐No

Do you have a history of keloid scarring (overly thickened scar)? ☐Yes ☐No

Have you taken Accutane or anticoagulants in the last 12 months? ☐Yes ☐No

Do you have permanent make-up, implants, or tattoos? If yes, list locations____________________

____

What is your current skincare regimen?____

____

Surgical History:(with approximate dates):

List below all hospitalizations for illnesses, operations, accidents, or fractures:

Year:_____________ Reason:____

Year:_____________ Reason:____

Year:_____________ Reason:____

Year:_____________ Reason:____

Cosmetic Procedures: (All that apply)

Do you currently get/use □Facials/Peel □Waxed □Electrolysis

□Depilatories □Microdermabrasion

Name:__________________________________Date of Birth_______________Date__________

Describe type(s), frequency & reaction(s):____

____

____

Have you ever had laser resurfacing? □Yes □No When, Type & Depth? __________________________

______________________ Describe your reaction: ____

Have you ever had Collagen/dermal filler injection(s)? □Yes □No

When & Type?________________________ Describe your Reaction_________________________________

____

Have you ever had Botox Injection(s)? □Yes □No When/Frequency? __________________________

__________________________Describe your reaction:____

Have you recently had facial or cosmetic surgery? □Yes □No When? ______________________________

_____________Describe:____

Allergies: (medication/food/latex/other):

____

Medications: (with dosages) including Over-The-Counter medications, supplements, and Topical:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Social History:

Do you smoke cigarettes/cigars/pipes (circle one)? □Yes □No

If yes, how much and how often?__________________________________

Do you use other nicotine products, such as nicotine gum or patch □Yes □No

Name:___________________________________Date of Birth____________Date___________

Do you drink Alcohol? ☐Yes ☐No

If yes how much and how often?____

Do you use any illicit drugs (medical confidentiality applies)? ☐Yes ☐No

If yes, what drugs and how often?____

Skin Description: (all that apply)

Describe your skin: ☐ Thick ☐ Thin ☐ Loose ☐ Firm ☐ Freckled ☐ Uneven/blotchy

☐ Normal ☐ Dry ☐ Oily ☐ Mature ☐ Wrinkled ☐ Melasma

☐ Rosacea ☐ Eczema ☐ Psoriasis ☐ Sun-damaged

☐ Hyper-pigmented

◻ Hypo-pigmented ◻ Dehydrated ◻ Patchy dryness

Skin Tone: ☐ Pale/White ☐ Light☐ Medium ☐ Reddish ☐ Freckled ☐ lt.olive

☐ Med.olive ☐ Dark Olive ☐ Lt.brown ☐ Medium Brown ☐ Dark Brown

☐ Soft Black ☐ Black

Describe your ethnic backround?

____

____

Do you redden or flush easily when you eat spicy food, drink alcohol, get angry, go in the sun etc?

____

All the information provided herein remains confidential and your email is not disclosed but used for communication to inform you of special events and discounts. **We look forward to making you look and feel your best.**

All appointments are secured with a credit card. Any appointment not cancelled or rescheduled prior to 48 hours notice will result in a $50.00 charge. No refunds are given for services rendered or products sold. If you are dissatisfied for any reason please notify us within 48 hours of your appointment to discuss.

I have completed this form to the best of my knowledge and will inform my therapist if any change in my medical condition occurs.

All procedures that are performed are for cosmetic purposes only.

Signature___________________________Witness______________________________ Date ___/___/___