

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 background?

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** __/__/__