Aesthetic Intake Form

Today's Date: _______________

Name: _________________________________ Age: ______ Date of Birth ___________

Address: ____________________________________ City: ___________ Zip: _________

Mobile Phone: _________________________ Okay to Contact ___ Leave Message ___

Home Phone: __________________________ Okay to Contact ___ Leave Message ___

Work Phone: __________________________ Okay to Contact ___ Leave Message ___

Email: ________________________________ Okay to Contact ___

Occupation: ___________________________ How did you hear about us? ______________

In order of importance, beginning with 1, please rank what you would like to see improved in your skin:

____ Reduction of wrinkles and fine lines ___ Reduction of brown spots/sun damage ___ Reduction of oil/acne ___ Reduction of Hair ___ Reduction of redness ___ Tattoo removal ___ Other: ____________

Medical History			Please check all medical conditions past or present		
	Yes	No		Yes	No
Are you or is it possible that you may be pregnant?			Keloid scarring		
Are you breastfeeding?			Cold sores		
Do you form thick or raised scars from cuts or burns?			Herpes (genital)		
After injury to the skin (such as cuts/burns) do you have: - Darkening of the skin in that area (hyperpigmentation) - Lightening of the skin in that area (hypopigmentation)			Easy bruising or bleeding		
			Active skin infection		
Hair removal by plucking, waxing, electrolysis of depilatory creams in the past 4 weeks?			Moles that have recently changed, itched, or bled		
Tanning (tanning bed) or sun exposure in the last 4 weeks?			Recent increase in amount of hair		
Tanning products or spray on tan in the last 2 weeks?			Asthma		
Do you have a tan now in the area to be treated?			Seasonal allergies/allergic rhinitis		
Do you use sunscreen daily with SPF 30 or higher?			Eczema		
Have you ever had a skin cancer? Type:			Thyroid imbalance		
List your common outdoor activities:			Poor healing		
Have you ever had a photosensitive disorder? (e.g. Lupus)			Diabetes		

	Yes	No		Yes	No
Do you have a personal history of seizures?			Heart condition		
Permanent make-up or tattoos? Where:			High Blood Pressure		
Have you used Accutane in the last 6 months?			Pacemaker		
Are you currently taking any antibiotics? What:			Disease of nerves or muscles (e.g. ALS, Myasthenia gravis, Lambert-Eaton or other)		
Are you using Retin-A or Glycolic products?			Cancer		
What is the name of your Primary Care Provider?			HIV/AIDS		
Do you have an allergy or sensitivity to lidocaine, latex, sulfa medications, hydroquinone, aloe, bee stings? (Circle)			Autoimmune disease (e.g. rheumatoid arthritis, Scleroderma)		
Life threatening allergy to anything?			Hepatitis		
Do you currently smoke?			Shingles		
DO you have scars on the face?			Migraine headaches		
Explanation of items marked "Yes":			Other illness, health problems or medical conditions not listed:		

Drug Allergies: ____

Current Medications:

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I certify that the information I have given is complete and accurate. ______ Initials ______Staff Initials

Is your skin: __ Dry __ Oily __ Normal __ Combination

Are you currently using any form of: __ Retin-A __ Differin __ Tazorac __ Glycolic Acid
__ Salicylic Acid __ Hydroquinone __ Other: ____

PLEASE INDICATE THE FOLLOWING CONCERNS: _____ NONE

☐ Acne	☐ Lip Lines	☐ Hair Reduction
☐ Enlarged Pores	☐ Lip Volume Loss	☐ Urinary Incontinence
☐ Brown Spots	☐ Nose-to-Mouth Lines	☐ Vaginal Dryness
☐ Fine Lines/Wrinkles	☐ Red Spots/Flushing	☐ Loss of Libido
☐ Facial Dryness	☐ Scarring	☐ Thinning Brows
☐ Facial Oiliness	☐ Skin Texture	☐ Hormones
☐ Facial Volume Loss	☐ Hair Loss	☐ Weight Loss
☐ Forehead	☐ Under Eye Circles/Crepiness	☐ Neck and Chest Discoloration
☐ Lines/Frown Lines	☐ Uneven Skin Texture	
☐ Other ________________	☐ Other __________________	☐ Other ____________________

Please Describe any adverse reactions to topical skin care products makeup, medications, or cosmetic treatments: ____
____
____

Do you feel your current skin care regimen is addressing your primary concerns listed today?
If no, please explain: ____
____

PLEASE INDICATE WHICH TREATMENTS YOU'VE RECEIVED: _____ NONE

☐ Rhytidectomy (Face lift) Date:	☐ Dermal Fillers Date:
☐ Rhinoplasty (Nose) Date:	☐ Botox Injections Date:
☐ Blepharoplasty (Eye lift) Date:	☐ Breast Augmentation Date:
☐ Laser Resurfacing Date:	☐ Breast Reduction Date:
☐ Medical Acid Peels Date:	☐ Liposuction Date:
☐ Collagen Injections Date:	☐ Tummy Tuck Date:
☐ Other ________________	☐ Other ____________________

Patient Signature: ____ Date: ________________

Skin Type Classification Questionnaire

	0	1	2	3	4	Score
What is the natural color of your hair?	Sandy Red	Blonde	Chestnut, dark brown	Dark brown	Black	
What is your eye color?	Light blue, Gray, Green	Blue, Gray, Green	Hazel	Dark brown	Brownish black	
What is the color of unexposed skin?	Reddish	Very pale	Pale with Beige Tint	Light brown	Dark brown	
How many freckles are on unexposed skin?	Several	Many	Some	Few	None	
What happens when you are in the sun TOO long without sunblock?	Painful redness, blistering, peeling	Burning followed by peeling	Burning followed by tanning	Rarely burns	Never burns	
How well do you turn brown?	Never	Some light color tan	Reasonable tan	Easily tan	Always tan	
Do you turn brown within one day of sun exposure?	Never	Seldom	Sometimes	Often	Always	
How does your face respond to the sun?	Very Sensitive	Sensitive	Normal	Little sensitivity	No sensitivity	
When did you last expose yourself to the sun or artificial sun treatments?	More than 3 months ago	2-3 Months ago	1-2 Months ago	Less than 1 month ago	Less than two weeks ago	
Do you normally expose the area to be treated to the sun?	Never	Seldom	Sometimes	Often	Always	
					TOTAL:	

Race (Check all that apply):

__ African American __ Asian __ Caucasian __ Hispanic
__ Mediterranean __ Native American __ Other: ______________________

00-07 Points = Skin Type 1
08-16 Points = Skin Type 2
17-25 Points = Skin Type 3
26-30 Points = Skin Type 4
31-40 Points = Skin Type 5 & 6