Patient Information

Patient Information as of today's date: ______________________

How did you hear about us? ____

(Please print legibly and fill in all fields. If information is not available, please put N/A.)

Personal Information

Patient Name: __________________________________ Date of Birth: ______________

Address: ____ Apt #: _________

City: ___________________________ State: __________________ Zip: ___________

Cell Phone: (______)________________ Email Address: ____________________________

Occupation: __________________________ Employer: ____________________________

Preferred Language: ___________________________ Sex: Male / Female

Emergency Contact Name: ______________________ Phone Number: __________________

Reason for your visit today? ____

Name of Primary Physician: _______________________ Date of last physical: ______________

Is your general health good? ◯ Yes ◯ No

Allergies? ◯ Yes ◯ No

If yes, please list: ____

List all medications you are taking (prescription and OTC):

____

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Do you take Aspirin, Advil, Motrin, Ibuprofen, or anti-inflammatory medication more than once/week?
○ Yes ○ No If yes, please explain: ____________________

Do you smoke: ○ Yes ○ No
If yes, how many per day/for how many years: ____________________

Do you drink alcohol: ○ Yes ○ No
If yes, how much/how often: ____________________

Do you regularly use a tanning bed or sun exposure? ○ Yes ○ No
If yes, how much/how often: ____________________

Do you regularly take vitamins? ○ Yes ○ No
If yes, what kind and how often: ____________________

Are you currently pregnant? ○ Yes ○ No Are you currently breastfeeding? ○ Yes ○ No

Are you currently trying to become pregnant? ○ Yes ○ No

Present/Past Medical History

Have you ever had any of the following (please check all that apply):

- ○ Arthritis
- ○ Asthma
- ○ Anemia
- ○ Autoimmune disorder
- ○ Blood disorder
- ○ Chest pain
- ○ Chronic diarrhea
- ○ Clotting disorder
- ○ Colon problems
- ○ Depression
- ○ Diabetes
- ○ Easily bruise
- ○ Excessive bleeding
- ○ Excessive scarring
- ○ Heart attack
- ○ Heart failure
- ○ Heart valve disease
- ○ Heart valve replacement
- ○ Hepatitis
- ○ High/low blood pressure
- ○ HIV
- ○ Intestinal problems
- ○ Irregular heartbeat
- ○ Keloids
- ○ Migraines
- ○ Multiple Sclerosis
- ○ Muscular Dystrophy
- ○ MVP
- ○ Rheumatic fever
- ○ Seizures
- ○ Shortness of breath
- ○ Stomach problems
- ○ Stroke
- ○ Tattoo/permanent makeup
- ○ Thyroid disorder
- ○ Unusual mole
- ○ Varicose veins
- ○ OTHER: ____________________

○ Cancer: Please list type: ____________________

Please list all surgeries or hospitalizations with dates:

____

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____

Please list any cosmetic procedures you have had (surgical and non-surgical) with dates:

___

___

___

Please describe your current skin care process:

___

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Please list any substances that irritate your skin:

___

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Please list any concerns that you have:

- ○ Fine lines / Wrinkles
- ○ Skin laxity
- ○ Age / Sun spots
- ○ Dry skin
- ○ Sensitive skin
- ○ Excess hair
- ○ Vascular Lesions
- ○ Tattoo Removal
- ○ Waxing
- ○ OTHER: ___

Please list any treatments or products that interest you:

- ○ Botox / Dysport / Xeomin
- ○ Restylane Dermal Fillers
- ○ Microneedling
- ○ CO2 Skin Resurfacing
- ○ Laser Hair Removal
- ○ Hyperpigmentation
- ○ Vascular Lesions
- ○ Tattoo Removal
- ○ Waxing
- ○ Signature Facial
- ○ DiamondGlow Facial
- ○ DermaplanePro Facial
- ○ Basic Facial
- ○ Rezenerate Facial
- ○ Subnovii Plasma Pen
- ○ Lash Lift & Tint
- ○ Brow Lamination & Tint
- ○ Laser Facial
- ○ Carbon Facial
- ○ Chemical Peels
- ○ OTHER: ___

To the best of my knowledge, the information provided above is true and accurate. I agree to tell the staff of any changes to my health history or medications as they arise. I understand that information is necessary for you practice and will remain confidential. All efforts are routinely made to ensure privacy is upheld.

Signature of Patient/Personal Representative: ___

Printed Name: ___ Date: ___