Appendix 1

Aesthetic Intake Form

Date:_____

NAME: _____ AGE:_____* Date of Birth:_____
Last, First

ADDRESS: _____ CITY:_____ ZIP: _____

MOBILE PHONE: _____ ☐ OK TO CONTACT ☐ LEAVE MESSAGE HERE

HOME PHONE: _____ ☐ OK TO CONTACT ☐ LEAVE MESSAGE HERE

WORK PHONE: _____ ☐ OK TO CONTACT ☐ LEAVE MESSAGE HERE

E-MAIL: _____ ☐ OK 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 or depilatory creams in the last 4 weeks?			Moles that have recently changed, itched, or bled		
Tanning (tanning bed) or sun expose 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		

(*Continued*)

Medical History			**Please check all medical conditions past or present**		
	Yes	No		Yes	No
Do you use sunscreen daily with SPF 30 or higher?			Eczema		
Have you ever had a skin cancer?			Thyroid imbalance		
List your common outdoor activities:			Poor healing		
Have you ever had a photosensitive disorder? (e.g. Lupus)			Diabetes		
Do you have a personal history of seizures?			Heart condition		
Permanent make-up or tattoos?			High blood pressure		
Have you used Accutane in the last 6 months?			Pacemaker		
Are you currently taking any antibiotics? Which:			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 regular physician:			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:		

* For minors, please request Guardian information form.

I certify that the information I have given is complete and accurate. _____Initials _____ Staff initials

For Internal Use Only Below This Line

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