CLIENT INTAKE FORM AND MEDICAL HISTORY

Date: _____ dd / mm / yyyy

First Name: _____

Last Name: _____

DOB: _____ dd / mm / yyyy

Phone Number: _____

Email: _____

Address: _____

Occupation: _____

Referred by: _____

MEDICAL HISTORY

Are you currently under the care of a physician for any reason?

◯ Yes ◯ No

If yes, for what?

List all medications, supplements, and vitamins

◯ Yes ◯ No

List all medications, supplements, and vitamins - Date/List/Comments

List allergies

◯ Yes ◯ No

List allergies - Date/List/Comments

Antibiotics

◯ Yes ◯ No

Antibiotics - Date/List/Comments

Birth Control Pills

◯ Yes ◯ No

Birth Control Pills - Date/List/Comments

Hormones

◯ Yes ◯ No

Hormones - Date/List/Comments

Aspirin, ibuprofen, use

◯ Yes ◯ No

Aspirin, ibuprofen, use - Date/List/Comments

Retin-A, Tretinoin

◯ Yes ◯ No

Retin-A, Tretinoin - Date/List/Comments

Glycolic acid on a regular basis

◯ Yes ◯ No

Glycolic acid on a regular basis - Date/List/Comments

Antidepressants

◯ Yes ◯ No

Antidepressants - Date/List/Comments

Sun reactions

◯ Yes ◯ No

Sun reactions - Date/List/Comments

Medication allergies

◯ Yes ◯ No

Medication allergies - Date/List/Comments

Food allergies

◯ Yes ◯ No

Food allergies - Date/List/Comments

Aspirin allergy

◯ Yes ◯ No

Aspirin allergy - Date/List/Comments

Lidocaine allergy

◯ Yes ◯ No

Lidocaine allergy - Date/List/Comments

Hydrocortisone allergy

◯ Yes ◯ No

Hydrocortisone allergy - Date/List/Comments

Hydroquinone allergy

◯ Yes ◯ No

Hydroquinone allergy - Date/List/Comments

Diabetes

◯ Yes ◯ No

Diabetes - Date/List/Comments

Smoking History

◯ Yes ◯ No

Smoking History - Date/List/Comments

Cold sores, herpes

◯ Yes ◯ No

Cold sores, herpes - Date/List/Comments

Bleeding disorders

◯ Yes ◯ No

Bleeding disorders - Date/List/Comments

Autoimmune, HIV

◯ Yes ◯ No

Autoimmune, HIV - Date/List/Comments

Pregnant or planning to be

◯ Yes ◯ No

Pregnant or planning to be - Date/List/Comments

Pacemaker

◯ Yes ◯ No

Pacemaker - Date/List/Comments

Implants of any kind: Dental, breast, facial

◯ Yes ◯ No

Implants of any kind: Dental, breast, facial - Date/List/Comments

Migraine headaches

◯ Yes ◯ No

Migraine headaches - Date/List/Comments

Glaucoma

◯ Yes ◯ No

Glaucoma - Date/List/Comments

Cancer

◯ Yes ◯ No

Cancer - Date/List/Comments

Arthritis

◯ Yes ◯ No

Arthritis - Date/List/Comments

Hepatitis

◯ Yes ◯ No

Hepatitis - Date/List/Comments

Thyroid imbalance

◯ Yes ◯ No

Thyroid imbalance - Date/List/Comments

Seizure disorder

◯ Yes ◯ No

Seizure disorder - Date/List/Comments

Active infection

◯ Yes ◯ No

Active infection - Date/List/Comments

Radiation in last 3 months

◯ Yes ◯ No

Radiation in last 3 months - Date/List/Comments

SKIN CONDITIONS

Acne

◯ Yes ◯ No

Acne - Date/List/Comments

Melasma

◯ Yes ◯ No

Melasma - Date/List/Comments

Tattoos, permeant makeup, and/or microblading

◯ Yes ◯ No

Tattoos, permeant makeup, and/or microblading - Date/List/Comments

Vitiligo

◯ Yes ◯ No

Vitiligo - Date/List/Comments

Keloid scarring

◯ Yes ◯ No

Keloid scarring - Date/List/Comments

Skin/laser treatments at another office

◯ Yes ◯ No

Skin/laser treatments at another office - If so, when? Results

Botox

◯ Yes ◯ No

Botox - If so, when? Results

Fillers

◯ Yes ◯ No

Fillers - If so, when? Results

Hair removal

◯ Yes ◯ No

Hair removal - If so, when? Results

chemical peels

◯ Yes ◯ No

chemical peels - If so, when? Results

Sun exposure/tanning bed in last week? self-tanner?

◯ Yes ◯ No

Sun exposure/tanning bed in last week? self-tanner? - If so, when? Results

Lit Medical Issues Not Listed Above

CURRENT SKIN CARE AND LIFESTYLE

How do you was your face?

◯ Soap ◯ Cleanser

If soap, what brand?: _____ **If cleanser, what brand?:** _____

Do you use a moisturizer?

Are you on a special diet?

◯ Yes ◯ No

If yes, please specify

Do you consume water daily?

◯ Yes ◯ No

If yes, how much?

Do you drink coffee, tea, or soda daily?

◯ Yes ◯ No

Coffee (ounces): _____ **Tea (ounces):** _____

Soda (ounces): _____

Do you exercise?

◯ Yes ◯ No

If yes, how often?

Have you ever had a facial?

◯ Yes ◯ No

If yes, when was your last facial?

Do you give yourself facials at home?

◯ Yes ◯ No

If yes, how often?

List additional cosmetics and skin care products you are currently using

WHAT IS THE PRIMARY REASON FOR YOUR VISIT TODAY? (SELECT ALL THAT APPLY)

Primary Reason for Visit

- ☐ I'm concerned about facial or body hair and would like information on ways to get rid it
- ☐ I'm concerned about fine lines around my eyes
- ☐ I'm concerned about scowl lines when I frown
- ☐ I'm concerned about pigmentation or age spots
- ☐ I'm concerned about broken capillaries on my face
- ☐ I'm concerned about skin laxity and sagging
- ☐ I'm concerned about the lines around my mouth

Other (please list skin concerns)

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician of my current medical and health conditions and to update this information at subsequent visits. A current history is essential for the provider to execute appropriate treatment procedures. I have signed the consent form for this procedure. I had the opportunity to ask questions prior to the treatment. I accept arbitration as a means of resolution for practice liability.

Client Signature

Date: _____ dd / mm / yyyy