

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

Lit Medical Issues Not Listed Above

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

CURRENT SKIN CARE AND LIFESTYLE

How do you wash 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