PATIENT REGISTRATION FOR SKIN TREATMENTS

CLIENT INFORMATION

First Name Last Name

Name____ E-Mail Address___________________________

Address____City___________________State_______Zip_____________

Home Phone_________________________ Work Phone_______________________ Fax___________________________

B/P______________T_________P________R________ ALLERGIES____

MEDICAL INFORMATION

Date of Birth________________ Age______ Family Physician _______________________Phone___________________

Do You Smoke?____How Often?______Live w/smoker?_____Do you drink Alcohol?____How Often?__________

Have you ever been treated for: *(please circle)*

*Acne *Depression *Skin Disease *High Blood Pressure *Cold Sores *Diabetes *Cancer * Sinus

Are you Pregnant?_____Trying to get Pregnant?______ Are you on Hormone therapy/Birth Control?_____________

Do you wear Contact Lenses?_________

PERSONAL INFORMATION

Circle your current level of stress: 1 2 3 4 5 6 7 8 9 10 Circle your normal level of stress: 1 2 3 4 5 6 7 8 9 10

Do you exercise?______How Often?______When was your last sunburn?_____Do you use tanning beds?__________

Have you had cosmetic surgery?____

Have you ever been under the treatment plan of a :

Dermatologist_____ Plastic Surgeon _____Aesthetician _____ Over the counter help_____

If so, were you satisfied with the results?____

What skin care line are you currently using?____

Cleanser______________________ Moisturizer______________________ Sunscreen______________________________

Eye Cream____________________ Mask____________________ Night Repair Cream_____________________________

Are you using or have you used (when)? ___Alpha/Beta Hydroxy Acids ___Retin-A ___Renova ___Accutane

Circle how you feel about the overall quality of your skin: 1(bad) 2 3 4 5 6 7 8 9 10 (fantastic)

Your skin type is ? (please circle ONLY one)

*Normal *Dry/Dehydrated *Oily *Acne/Acne Prone

In order of importance, beginning with 1, make a wish list of what you would like to see improved in your skin in the next 30 days……

_____Reduction in fine lines
_____Reduction of oil/Acne
_____Reduction of brown spots/Sun Damage
_____Acne scars diminished

Please check all treatments/services that interest you:

_____Professional Skin Care Program
_____Skin Peel Treatments
_____Botox/Dysport
_____Dermal Fillers
_____Dermal planing
_____Liquid Face Lift/PDO Thread Lift
____Plasma
____Micro needling
____Fat Reduction Injections

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Do you have any of the following medical conditions? (Please check all that apply):

☐Cancer	☐Acid Re-flux	☐Anemia	☐Anxiety	☐Artificial Heart Valve	☐Artificial Joints
☐ADHD	☐Asthma	☐Autism	☐Arthritis	☐Bleeding Disorders	☐Cerebral Palsy
☐Chicken pox	☐Convulsions	☐Depression	☐Diabetes	☐Dizziness/Fainting	☐Epilepsy/Seizures
☐Headaches	☐Hepatitis	☐Heart Attack	☐Herpes	☐Heart Murmur	☐Hearing Problems
☐HIV/AIDS	☐High blood pressure	☐Heart Murmur	☐Stroke	☐Sinus Problems	☐Pacemaker
☐Tuberculosis	☐Cold sores	☐Kidney Problems	☐Keloid scarring	☐Skin disease/ Skin lesions	☐Tuberculosis
☐Hormone imbalance	☐Thyroid imbalance	☐Blood clotting abnormalities	☐Any active infection	☐Ulcers ☐Tumors	☐Radiation Chemo

☐Any Other Health Problems:____

ALLERGIES

Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced)

☐Food ☐Animal Protein ☐Aspirin ☐Lidocaine ☐Hydrocortisone ☐Hydroquinone or skin bleaching agents ☐Other Allergies:

____

____

MEDICATIONS

What oral prescription medications are you presently taking, please list all the medications:

____

Are you taking any of the following ☐Hormones ☐Cortisone ☐Antidepressant

☐Others (It is required that you list all medication): ____

____

What antibiotics do you use to treat infections?____

Do you take any medications for heart conditions? ____

Are you on any mood altering or anti-depression medication?_____________________________________

What herbal supplements do you use regularly?____

Please list any other medication:____

CONSENT FOR TREATMENTS AND PHOTO RELEASE

I hereby authorize and consent to having photographs taken of me and that they may be used as an aid in my treatment, in marketing, or study reporting purposes and that any photographs taken will remain the property of the facility. I understand that my identity will be kept strictly confidential. I also understand that these photographs will help document the progress of my treatment. I certify that the information given is true to the best of my knowledge and certify that I will notify the office immediately if any changes occur in my medical history/health status.

Patient Signature____ **Date**________________________

Referred by:____