



COSMETIC PATIENT HISTORY FORM

Date: _____

Full Name <i>(please print clearly)</i>		Date of Birth
Street Address		
City	State	Zip Code
Cell Phone	Other Phone	
()	()	
Email		

Personal Health History

Are you taking or have recently used any of the following?

- | | | |
|--|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin/Motrin/Advil/Coumadin/Heparin | <input type="checkbox"/> Accutane | <input type="checkbox"/> Retinoid |
| <input type="checkbox"/> Glycolic Acid/ Alpha Hydroxy Acid | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Hydroquinone |

If yes, how recent? _____

Have you experienced or do you have a history of:

- | | | |
|---|--|--|
| <input type="checkbox"/> Keloid formation/ scarring | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Endocrine/ hormone issues |
| <input type="checkbox"/> Permanent Makeup-tattoo | <input type="checkbox"/> Lupus | <input type="checkbox"/> Hepatitis (List Type) _____ |
| <input type="checkbox"/> Melanoma/ Skin cancer | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Herpes/Cold Sores/ Fever Blisters |

List any allergies:	List any medications you are currently taking:

- | | | |
|---|------------------------------|---|
| Have you ever had an allergic reaction to any skin product or cosmetic? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you on hormone replacement therapy or birth control pills? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you pregnant or planning to be? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you breast feeding? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a history of tobacco use? | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Quit |

Have you previously had any of the following Cosmetic Procedures?

- | | | |
|---|--|---|
| <input type="checkbox"/> Fillers _____ | <input type="checkbox"/> Botox | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> Chemical Peel | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Photo Rejuvenation (IPL) | <input type="checkbox"/> Vein Therapy | <input type="checkbox"/> Non-ablative Skin Rejuvenation (Laser genesis) |

Skin Type (when exposed to the sun for 1 hour without sun screen)

- | | |
|---|--|
| <input type="checkbox"/> White, always burns, never tans (I) | <input type="checkbox"/> Medium brown, rarely burns, fast tanning (IV) |
| <input type="checkbox"/> Beige, usually burns, tans with difficulty (II) | <input type="checkbox"/> Dark brown, rarely burns, fast and easy tanning (V) |
| <input type="checkbox"/> Light brown, sometimes burns, slow tanning (III) | <input type="checkbox"/> Black, almost never burns, fast and dark tanning (VI) |

Patient family history

	Yes	Afflicted Family Member
Abnormal Bleeding		
Abnormal Clotting		
Anesthesia Problems		
Autoimmune Disorder		
Breast Cancer		
Brain Tumor		
Other Cancer		
Cleft Lip		
Cleft Palate		
Diabetes		
Drug Allergies		
Endocrine Disease		
Hearing Loss		
Heart Disease		
High Blood Pressure		
Hemophilia		
Kidney Disease		
Liver Disease		
Lung Cancer		
Malignant Hyperthermia		
Ovarian Cancer		
Prostate Cancer		
Skin Cancer		
Skin Disease		
Substance Abuse		
von Willebrand		
Other (please list all that apply)		

NONE

Patient / Guardian Signature

Date



COSMETIC INFORMATION REQUEST FORM

Please let us know if you would like additional information regarding any of the following cosmetic services and procedures:

- | | |
|--|---|
| <input type="checkbox"/> Botox | <input type="checkbox"/> Waxing |
| <input type="checkbox"/> Superficial chemical peels | <input type="checkbox"/> HydraFacial MD |
| <input type="checkbox"/> Injectable fillers (Juvederm/Radiesse/Belotero) | <input type="checkbox"/> miraDry (permanent sweat reduction) |
| <input type="checkbox"/> Laser Genesis (rosacea/redness/texture) | <input type="checkbox"/> truSculpt (body contouring) |
| <input type="checkbox"/> Pearl (skin rejuvenation for sun damage and wrinkles) | <input type="checkbox"/> Eyebrow and eyelash tinting |
| <input type="checkbox"/> Solar Genesis (sun spots and freckling) | <input type="checkbox"/> Isolaz (acne/ deep pore cleansing) |
| <input type="checkbox"/> Kybella (permanent chin fat treatment) | <input type="checkbox"/> Dermaplaning |
| <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> Advanced anti-aging skin care products |
| <input type="checkbox"/> Spider vein & facial vein treatment | <input type="checkbox"/> Latisse (for longer, darker eyelashes) |
| <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Extractions |

How did you hear about us?

- Family / friend referral Physician referral Internet / Website Insurance Provider
 Other: _____

Please let us know how to best contact you:

Name: _____

Home Phone: _____

Cell Phone: _____

Mailing Address: _____

Email Address: _____



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