South Jersey SKIN CARE & Laser Center

COSMETIC PATIENT HISTORY FORM

Date: _____

Full Name *(please print clearly)*		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?

☐ Aspirin/Motrin/Advil/Coumadin/Heparin ☐ Accutane ☐ Retinoid
☐ Glycolic Acid/ Alpha Hydroxy Acid ☐ Antibiotics ☐ Hydroquinone ☐ None

If yes, how recent? _____

Have you experienced or do you have a history of :

☐ Keloid formation/ scarring ☐ HIV/AIDS ☐ Endocrine/ hormone issues
☐ Permanent Makeup-tattoo ☐ Lupus ☐ Hepatitis (List Type) _____ ☐ None
☐ Melanoma/ Skin cancer ☐ Easy Bruising ☐ 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? ☐ Yes ☐ No
Are you on hormone replacement therapy or birth control pills? ☐ Yes ☐ No
Are you pregnant or planning to be? ☐ Yes ☐ No
Are you breast feeding? ☐ Yes ☐ No
Do you have a history of tobacco use? ☐ Yes ☐ No ☐ Quit

Have you previously had any of the following Cosmetic Procedures?

☐ Fillers_____ ☐ Botox ☐ Surgery
☐ Laser Hair Removal ☐ Chemical Peel ☐ Microdermabrasion ☐ None
☐ Photo Rejuvenation (IPL) ☐ Vein Therapy ☐ Non-ablative Skin Rejuvenation (Laser genesis)

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

☐ White, always burns, never tans (I) ☐ Medium brown, rarely burns, fast tanning (IV)
☐ Beige, usually burns, tans with difficulty (II) ☐ Dark brown, rarely burns, fast and easy tanning (V)
☐ Light brown, sometimes burns, slow tanning (III) ☐ 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**

South Jersey SKIN CARE & Laser Center

COSMETIC INFORMATION REQUEST FORM

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

_____ Botox
_____ Superficial chemical peels
_____ Injectable fillers (Juvederm Family)
_____ Laser Genesis (rosacea/redness/texture)
_____ PRP for hair loss
_____ IPL (sun spots, freckling, skin rejuvenation & wrinkles)
_____ Thread Lift (loose & sagging skin)
_____ Laser Hair Removal
_____ Spider vein & facial vein treatment
_____ Microdermabrasion
_____ Microneedling/PRP
_____ HydraFacial MD
_____ miraDry (permanent sweat reduction)
_____ CoolSculpting (fat reduction)
_____ Eyebrow and eyelash tinting/ Waxing
_____ Isolaz (acne/ deep pore cleansing)
_____ Dermaplaning
_____ Advanced anti-aging skin care products
_____ Latisse (for longer, darker eyelashes)
_____ 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: _____

Like us on Facebook for exclusive Facebook offers

Ask about our free consultations.