Aesthetic Client Medical Information

Name: _____ Age: _____ Date: _____

Please list all medications you are currently taking (*including over the counter medications,vitamins & herbs*):

_____

_____

_____

Please list any previous surgeries you have had: _____

Please list any allergies you have to medications: _____

Do you have skin-related allergies?_____

Have you ever had an allergic reaction to anesthesia? _____

How much water do you drink on an average day? _____

How much alcohol do you consume? _____

Do you smoke? _____ If yes, how much? _____

How high is your sun exposure? _____ Do you use sunscreen? _____ What is the SPF? _____

What type of problem are you here for today? _____

How long have you noticed this problem? _____

Have you ever been treated for this problem and if so, by what method? _____

Have you had other skin treatments in the past? _____

My specific areas of concern are (ie: eyes, forehead, etc): _____

What is your skin type?

_____ Very white or freckled. Always burn on exposure to summer sun. (Fitzpatrick I)
_____ White. Usually burn on exposure to summer sun. (Fitzpatrick II)
_____ White to olive. Sometimes burn on exposure to summer sun. (Fitzpatrick III)
_____ Brown. Rarely burn on exposure to summer sun. (Fitzpatrick IV)
_____ Dark brown. Very rarely burn on exposure to summer sun. (Fitzpatrick V)
_____ Black. Never burn on exposure to summer sun. (Fitzpatrick VI)

Client Signature: _____ Date: _____

Thank you for your time.
Your answers will assist us in developing a treatment plan designed for your individual needs.

I have reviewed this information with the client. Client is approved for:

_____ Retin A
_____ HQ 2%, 4%, 6%, 8%
_____ Topical lido/tetracaine
_____ Dermaplaning
_____ Rejuvapen (basic)
_____ Rejuvapen (PRP)

for a period of 12 months from today's date _____

Do any of the following conditions relate to you? Please make an X in the appropriate box:

Yes	No	
		Accutane or other acne medication
		Allergic reaction to Lidocaine or Tetracaine or Allergy to Latex
		Autoimmune disease, HIV, Lupus
		Bleeding disorder or easy bruising
		Blood thinners - Aspirin, Coumadin, Warfarin, Eliquis, Xarelto, Plavix, or Pradaxa
		Botox - last treatment date:_____
		Cancer or post-cancer treatments (chemotherapy or radiation) If yes, date of last treatment:_____
		Chemical peel - last treatment date:_____
		Chemical sun tanning lotions or Spray tan
		Cold sores or Fever blisters
		Contact lenses
		Cortisone or steroid injections
		Cosmetic injections, fillers, or implants (ie: Restylane, Juvederm, Radiesse, Sculptra, Bellafil)
		Diabetes
		Eczema or Psoriasis
		Epilepsy, Seizure disorder
		Facial waxing services or Electrolysis within the last 7-14 days
		Heart disease: previous heart attack, congestive heart failure, irregular heartbeat, leaky valves
		High blood pressure
		Hepatitis A, B, C, or D or other liver disease
		Irregular moles, warts, or growths; suspicious or changing skin lesions
		Keloids, pigmented scars, or longstanding acne scars
		Laser procedures, dermabrasion, or microdermabrasion in the past
		Light sensitive medication (cipro, doxycycline, bactrim, nifedipine, diltiazem, benadryl, lasix, HCTZ)
		Lymphatic disorder, inflammation of lymph vessels, lymphedema, or swollen/ painful glands
		MRSA
		Pacemaker, metal implants or artificial joint
		Phlebitis, varicose or spider veins
		Pregnant or breast feeding
		Previous Face Lift or Forehead/ Brow Lift
		Recent surgery, dental procedure, accident or serious injury or recent viral infection
		Rosacea, telangiectasias, couperose skin
		Using Retinol, Retin-A, Tretinoin, Renova, Glycolic Acid, Alpha-hydroxy Acid, Hydroquinone, or Skin Lightening Agents
		Sunburn, either recent or multiple severe burns in the past
		Take medication before dental work
		Thyroid condition
		Other disease or disorder not listed - please specify:_____

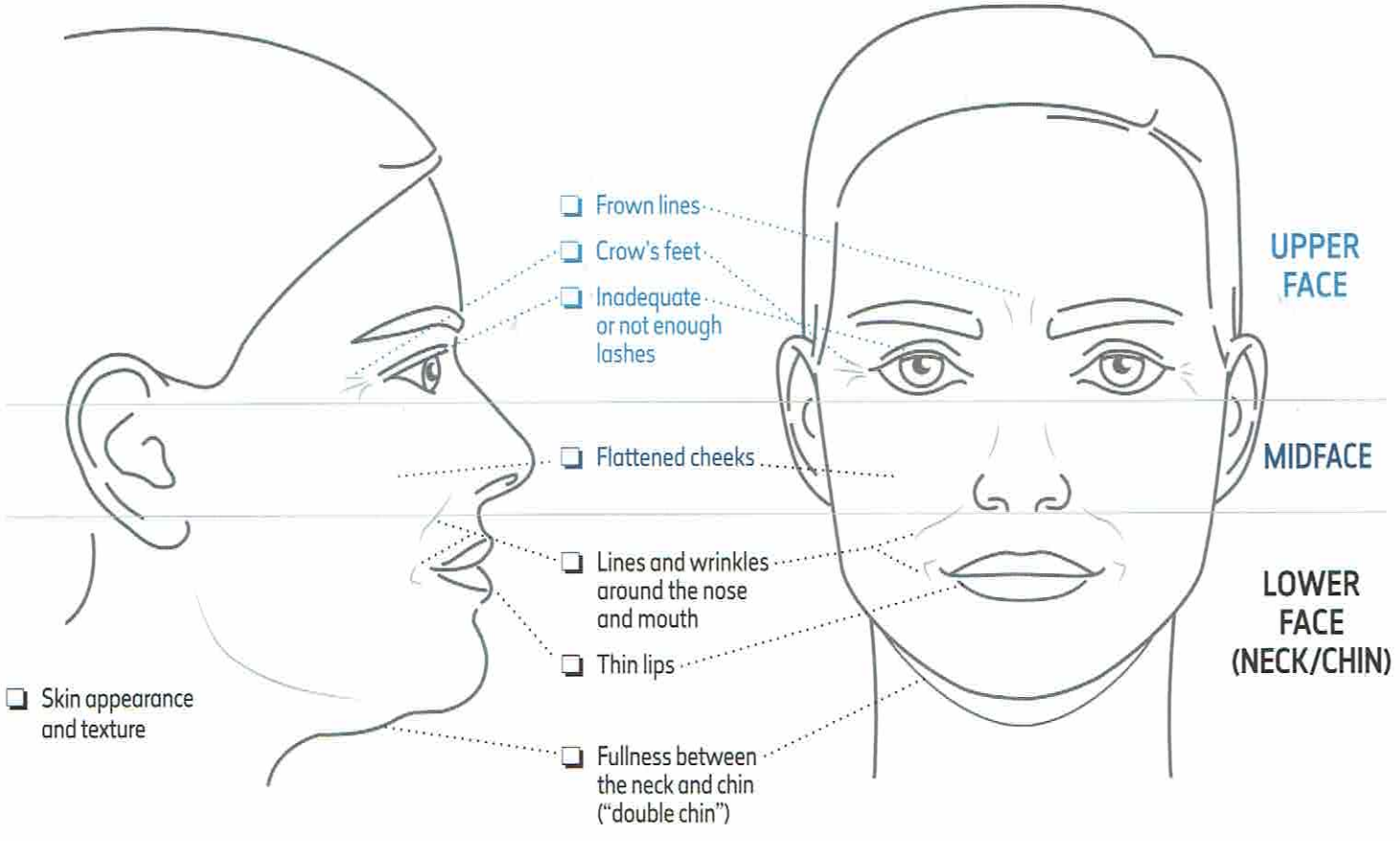
SELF-ASSESSMENT

NAME: _____ DATE OF BIRTH: _____ DATE: _____

What brings you in today? _____

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.



Please complete and return this form to the front office before your consultation.