

Aesthetic Patient Profile (note: our aesthetic patient records are kept separate from our medical practice records)

Name: _____ Date: _____
Last First Middle

Date of Birth: _____ Age: _____

Address: _____ City/State/Zip: _____

Home phone: _____ Work phone: _____

Preferred number for us to call: Home Work

E-mail address: _____
(Occasionally, we notify our customers about specials and promotions by e-mail)

Reason for your visit: _____

How would you describe your skin type?

- Normal
- Oily
- Combination
- Dry

With sun exposure, Does your skin?

- Always burns/never tans
- Sometimes burns/sometimes tans
- Seldom burns/usually tans
- Almost never burns/always tans

Do you currently have, or have you had, any of the following skin conditions (please provide details):

- Acne
- Sun-induced Eruptions (Lupus)
- Abnormal Nevi (Moles)
- Skin Cancers or Precancers
- Rosacea
- Eczema
- Allergic Contact Rashes
- Other: _____

Current Medication list (including birth control): _____

Allergies: _____

For females: Are you pregnant or nursing? No Yes

Do you currently have, or have you had, any of the following medical conditions (please check boxes and provide details):

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Ultraviolet Light Therapy |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness or Fainting |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Liver Disease/Jaundice | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Psychiatric/emotional illness |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Intestinal Colitis | <input type="checkbox"/> Cold Sores or Fever Blisters |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Keloids/thick scars |
| <input type="checkbox"/> Breathing difficulty | <input type="checkbox"/> Cancer | <input type="checkbox"/> Problems with Local Anesthesia |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Problems with Healing |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hepatitis/Aids exposure | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other: _____ | |

Are you on blood thinners? Yes No _____

Have you used Accutane (give date and response)? Yes No _____

Do you currently use, or have you used, any of the following products (if so, please describe)?

- Retin A, Renova, or other retinoid: _____
- Alpha hydroxy acids: _____
- Sunscreen (what type): _____
- Current skin care products: _____

Have you had any of the following procedures performed (if so, please describe)?

- Chemical peels: _____
- Microdermabrasion: _____
- Laser resurfacing or other laser procedures: _____
- Facial surgery: _____

- Botox injections: _____
- Collagen injections: _____
- Other procedures: _____

Do you have any interest in the following products or treatments?

Home skin care products	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Need more information
Sunscreens	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Need more information
Chemical peels	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Need more information
Microdermabrasion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Need more information
Botox for wrinkle reduction	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Need more information
Dermal fillers	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Need more information
Laser hair removal	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Need more information
Treatment of facial blood vessels	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Need more information
Spider vessel or varicose vein treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Need more information
Resurfacing of the skin	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Need more information

What do you hope to achieve through aesthetic treatments? _____

Client Signature: _____

Date: _____

Reviewed by: _____

Date: _____