Medical Aesthetics Intake Form

Patient's Name _____ Date of Birth _____
Address _____ City, State, Zip Code _____
Home Phone _____ Cell Phone _____
Would you like to receive emails regarding specials, discounts and appointment confirmations?
▫Yes ▫No E-Mail _____
How did you hear about us? _____

Medical History

Are you currently seeing a physician for any reason? ▫Yes ▫No
If yes, please explain reason _____
Have you ever seen a physician or aesthetician specifically for a skin problem or skincare? ▫Yes ▫No
If yes, when and for what reason _____
Are you currently under the care of a physician or aesthetician for your skin? ▫Yes ▫No
If yes, please explain reason _____
Have you or a family member have a history of skin cancer? ▫Yes ▫No
If yes, please explain _____
Do you have any health problems? ▫Yes ▫No
If yes, please explain _____
Are you pregnant or breastfeeding? ▫Yes ▫No
Do you have any skin allergies or sensitivities? ▫Yes ▫No
If yes, please explain _____
Do you use any topical medications (Retin-A, other prescribed acne medications, antibiotics etc.)?
▫Yes ▫No
If yes, please list all topical medications_____
Do you take any oral medications (oral hormones, birth control pills, antibiotics, hypertension, etc.)?
▫Yes ▫No
If yes, please list _____
Have you ever been prescribed Accutane or any other oral retinoid? ▫Yes ▫No
If yes, please list dates of duration _____
Have you ever had a cold sore? ▫Yes ▫ No
If yes, when was the last time you had one? _____

Skincare History

Do you have any of the following skin issues?
▫Fine Lines ▫Deep Wrinkles ▫Skin Laxity ▫Volume Loss ▫Brown Spots
▫Tone/Texture ▫Large Pores ▫Acne ▫Redness ▫Dull Skin

Do you have a history of acne or breakouts? ▫Yes ▫No
Do you only experience acne or breakouts around your menstrual cycle? ▫Yes ▫No
Would you describe your skin type as ▫Normal ▫Combination ▫Oily ▫Dry
Do you flush or redden when eating spicy foods, drink alcohol, get angry or are in the sun?▫ Yes ▫No
How does your skin react when you are exposed to the sun?

▫I Always Burn ▫ II Usually Burn ▫III Sometimes Burn ▫IV Rarely Burn
▫V Never Burn (Brown) ▫VI Never Burn (Black)

Do you wear sunscreen daily ▫Yes ▫No If yes, what is the SPF? _____
Have you had any unprotected natural sun or tanning bed exposure in the last 6 weeks? ▫Yes ▫No

Do you currently use skincare products on a daily basis? ▫Yes ▫No
What skincare products are you currently using?

_____ _____
_____ _____

Have you ever had?	If yes, when was your last treatment?
Facial	_____
Chemical Peel (Lactic, Salicylic, Glycolic, TCA, Other)	_____
Microdermabrasion or Dermaplaning	_____
Waxing	_____
Botox	_____
Filler (Restylane, Radiesse, Juvederm, Voluma, etc.)	_____
Laser Treatment	_____
Cosmetic Surgery	_____

Are you interested in learning more about any of the following services and treatments that we offer?

▫Facials ▫Chemical Peels ▫Microdermabrasion ▫Dermaplaning ▫Waxing
▫ Skincare Products ▫Mineral Make Up ▫Botox ▫Fillers

What skin issues would you like to address today?
1._____
2._____
3._____

_____ _____ _____
Patient's Name (Please Print) Patient's Signature Date

_____ _____
Provider's Signature Date