Aesthetic Intake Form

Wendy Roberts, CANP

Date:_____

Name:_____DOB:_____

Address:_____City:_____State:_____Zip:_____

Email:_____Home/Cell:_____

Employer:_____Work:_____

Emergency Contact:_____Relation:_____Phone:_____

How did you hear about us?_____

Medications

Please list any/add medications or supplements you are currently taking:_____

_____

_____

Are you taking any medications for high blood pressure? ____Yes ____No If yes, name(s):_____

Are you taking aspirin or any type of blood thinner? ____Yes ____No If yes, name:_____

Are you taking: ____Retin-A ____Differin ____Hydroquinone ____Renova ____Accutane (in past 6 months)

Other Skin Care Medications/Topical Agents:_____

Allergies

Please list any & all medication allergies:_____

Are you allergic to Latex? ____Yes ____No

Are you allergic to Iodine? _____Yes_____No

Conditions

Are you pregnant or planning on becoming pregnant? ___Yes___No Are you currently breastfeeding? ___Yes ___No

Do you wear contact lenses? ____Yes ____No Do you have metal implants? ____Yes ____No

Previous Procedures

Which of the following have you had in the past?

____Botox ____Juvederm ____Radiesse ____Restalyne ____Other Injectables:_____

____Microdermabrasion ____Chemical Peels ____Electrolysis ____Waxing ____Laser Hair Removal

Details:_____

_____

Medical History - Please check all that apply:

____Alcoholism ____Anemia ____Anorexia ____Asthma ____Autoimmune Disease ____Fibromyalgia ____Hepatitis

____Herpes/Cold Sores ____HIV/Aids ____Hypertension____History of Keyloid Scarring ____Bleeding Disorder

____Breast Lump____Cancer ____Connective Tissue Disorder ____Chemical Dependency ____Migraines

____Multiple Sclerosis____Neuromuscular Disease ____Pacemaker/Defibrilltor ____Ploycystic Ovaries

____Urinary Tract Infections____Joint Pains_____Lyme Disease ____High Cholesterol____Headaches

____Chronic Fatigue____Diabetes____Eating Disorders ____Epilepsy ____Pigmentation Disorder ____Seizures

____Skin Lesion____Other (please explain)_____

Skin Care

What is your daily skin regimen?_____

_____

Sun History and Lifestyle

How often are you outdoors? ____Frequently ____Occasionally ____Very Rarely

Is there a family history of skin cancer? ____Yes ____No If so, who? _____

How often do you use sunscreen? ____Frequently ____Occasionally ____Very rarely

How often do you use tanning beds? ____Frequently ____Occasionally ____Very Rarely

Which of the following best describes your skin type?

____Very oily, large pores ____Oily Skin ____Dry Skin ____Sensitive Skin

____Combination skin, oily T-Zone with dry to normal cheeks

Concerns/Interests

____Hair Removal ____Acne ____Rosacea ____Dryness ____Fine Lines ____Wrinkles ____Pore Size

____Discoloration ____Loss of Skin Tone ____Pigmentation ____Brown Spots ____Broken Capillaries/Veins

Other_____

Authorization and Release – I herby certify that I have completed the above information to the best of my knowledge.

Client Signature:_____Date:_____

Review by:_____Date:_____