Appendix 2

# Aesthetic Intake Form

Date:_____

NAME: _____ AGE:_____* Date of Birth:_____
Last, First

ADDRESS: _____ CITY:_____ ZIP: _____

MOBILE PHONE: _____ ☐ OK TO CONTACT ☐ LEAVE MESSAGE HERE

HOME PHONE: _____ ☐ OK TO CONTACT ☐ LEAVE MESSAGE HERE

WORK PHONE: _____ ☐ OK TO CONTACT ☐ LEAVE MESSAGE HERE

E-MAIL: _____ ☐ OK TO CONTACT

OCCUPATION: _____ How did you hear about us?: _____

In order of importance, beginning with 1, please rank what you would like to see improved in your skin: _____ Reduction of wrinkles and fine lines _____ Reduction of brown spots/sun damage _____ Reduction of oil/acne _____ Reduction of Hair _____ Reduction of redness _____ Tattoo Removal _____ Other: _____ _____

| **Medical History** | | | **Please check all medical conditions past or present** | | |
|---|---|---|---|---|---|
| | Yes | No | | Yes | No |
| Are you or is it possible that you may be pregnant? | | | Keloid scarring | | |
| Are you breastfeeding? | | | Cold sores | | |
| Do you form thick or raised scars from cuts or burns? | | | Herpes (genital) | | |
| After injury to the skin (such as cuts/burns) do you have:<br>Darkening of the skin in that area (hyperpigmentation)<br>Lightening of the skin in that area (hypopigmentation) | | | Easy bruising or bleeding | | |
| | | | Active skin infection | | |
| Hair removal by plucking, waxing, electrolysis or depilatory creams in the last 4 weeks? | | | Moles that have recently changed, itched, or bled | | |
| Tanning (tanning bed) or sun expose in the last 4 weeks? | | | Recent increase in amount of hair | | |
| Tanning products or spray on tan in the last 2 weeks? | | | Asthma | | |
| Do you have a tan now in the area to be treated? | | | Seasonal allergies/ allergic rhinitis | | |

(*Continued*)

| **Medical History** | | | **Please check all medical conditions past or present** | | |
|---|---|---|---|---|---|
| | Yes | No | | Yes | No |
| Do you use sunscreen daily with SPF 30 or higher? | | | Eczema | | |
| Have you ever had a skin cancer? Type: | | | Thyroid imbalance | | |
| List your common outdoor activities: | | | Poor healing | | |
| Have you ever had a photosensitive disorder? (e.g. Lupus) | | | Diabetes | | |
| Do you have a personal history of seizures? | | | Heart condition | | |
| Permanent make-up or tattoos? Where: | | | High blood pressure | | |
| Have you used Accutane in the last 6 months? | | | Pacemaker | | |
| Are you currently taking any antibiotics? Which: | | | Disease of nerves or muscles (e.g. ALS, Myasthenia gravis, Lambert-Eaton or other) | | |
| Are you using Retin-A or Glycolic products? | | | Cancer | | |
| What is the name of your regular physician: | | | HIV/AIDS | | |
| Do you have an allergy or sensitivity to lidocaine, latex, sulfa medications, hydroquinone, aloe, bee stings? (circle) | | | Autoimmune disease (e.g. rheumatoid arthritis, Scleroderma) | | |
| Life threatening allergy to anything? | | | Hepatitis | | |
| Do you currently smoke? | | | Shingles | | |
| Do you have scars on the face? | | | Migraine headaches | | |
| Explanation of items marked "Yes": | | | Other illness, health problems or medical conditions not listed: | | |

* For minors, please request Guardian information form.

I certify that the information I have given is complete and accurate. _____Initials _____ Staff initials

**For Internal Use Only Below This Line**

_____

_____

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_____

**Please mark the places you would like to treat on a scale of 1 to 10, 1 being the highest priority**