Intake Form

Demographics:

Name _____

Address _____

E-mail Address_____ Phone _____ DOB _____

Emergency Contact Name and Phone _____

Relationship _____ Primary care physician _____

Medical History:

Current or past medical conditions

_____

_____

_____

Have you had any surgeries before, including facial procedures?

_____

_____

_____

Are you currently pregnant or breastfeeding? Yes No

What facial wrinkles would you like to treat? If so, what areas of your face would you like to see improvement in?

_____

_____

_____

Have you received any previous aesthetic injections in the past? If so, what was injected? Any issues after injection?

_____

_____

Do you have any specific skin diseases or conditions, such as psoriasis or acne? If so, please describe:

_____

_____

_____

Do you have any allergies to eggs, botulinum toxin or latex? If so, please explain:

_____

_____

_____

Do you have any current or past medical history of a neuromuscular disorder (such as: myasthenia gravis, ALS, eaton-lambert syndrome, bells palsy, etc). Yes No

Are you traveling out of state in the next 2 weeks? Yes No

Do you have any important events or pictures in the next 2 weeks? Yes No

Are you planning Lasik Eye Surgery or any Plastic surgery procedure? Yes No

Are you a routine blood donor? Yes No

Do you have any current (within the last 2 weeks) or active infections or illnesses (herpes, hives, dermatitis, etc…)? If so, what medications (prescribed or over the counter) have you taken for it?

_____

_____

_____

Please list all current prescription medications and how often you take them, including blood thinners like aspirin and over the counter medication:

_____

_____

_____

Signature of Client: Date:

Grace
AESTHETICS AND WELLNESS