## Patient Information

Name ______________________________________________ DOB ____________________

Address ______________________________________________________________________

Phone ________________________________________ Text Reminders (circle): YES NO

Email ________________________________________ Referral Source __________________

Reason for visit ______________________________________________________________

## Skin Type

*Circle all that apply*

| | | | | |
|---|---|---|---|---|
| **Your skin is?** | Oily | Dry | Combination | |
| **How do you tan?** | Burn | Burn then tan | Usually tan | |
| **Skin pigmentation?** | Even | Uneven | Birthmarks | Pregnancy Mask |
| **Broken capillaries?** | Nose | Cheeks | Chin | Forehead |
| **You have:** | Pimples | Blackheads | Flakiness | Whiteheads |
| | Enlarged Pores | | Acne Scars | |

**You would like to improve:**

| | | |
|---|---|---|
| Fine Lines | Worry Lines | Marionette Lines |
| Facial Scars | Moles | Large Pores |
| Acne Scars | Deep Smile Lines | Sun Damage |
| Frown Lines | Crow’s Feet | Color Irregularities |
| Overall Skin Tone | Lip Shape/Size | |

**Skincare products you currently use:** ______________________________________________

______________________________________________________________________________

______________________________________________________________________________

## Personal Health History

Medication Allergies ___________________________________________________________

Current Medications: ___________________________________________________________

______________________________________________________________________________

***Circle all that apply***

**You have:**

Liver Disease/Disorder

Cardiovascular Disease/Disorder

Lymphatic Disease/Disorder

Thyroid Gland Disorder

Cancer (active within 1 yr.)

Uncontrolled Hypertension

Compromised Immune System

History of Cold Sores

Skin Lesions/Sores

Photosensitivity

Accutane (6 mo.)

Hypertrophic Scarring

**Females only:**

Regular Periods

Taking birth Control

Menopause

Taking Estrogen

Experienced Pregnancy Mask

Pregnant

Breastfeeding

## Acknowledgements

*Initial for consent*

________I consent to taking before/after photos that will be used to track my progress
________I consent to letting my before/after photos be used on all social media platforms
________I understand there are no guarantees to the results of my treatments. I understand to achieve the maximum results, I may require several treatments.
________To achieve optimal results, it is recommended I follow the prescribed skincare regimen and avoid sun exposure without recommended sunscreen.
________I understand it is my personal responsibility to inform the clinic of any changes to my medical history during the course of my treatment sessions.
________I am fully aware that my condition is of a cosmetic concern and the decision to proceed is based solely on my expressed desire to do so.
________I understand the privacy and security standards used to protect the confidentiality of my health information (HIPPA). If not, I can request a copy at the front.

I HAVE READ THIS FORM ENTIRELY AND HAVE COMPLETED IT FULLY AND ACCURATELY TO THE BEST OF MY KNOWLEDGE.

Date this form was completed: ______________

Patient Signature: ___________________________________