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‡Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ‡Date of Birth: / / Age: \_\_\_\_\_\_\_\_

‡Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ‡City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ‡State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ‡Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ‡Cell Phone :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ‡Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ‡How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

‡**CONSENT TO DISCLOSE / EMERGENCY CONTACT IS REQUIRED:** In an effort to protect your medical and aesthetic information, please list all names of those whom we have permission to discuss appointment dates/times, billing, and medical information with. **We cannot discuss this information with your spouse, relatives or friends without this consent.**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

## Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  **Medical History Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Ethnicity (ie, German, French…)\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_Height: \_\_\_\_\_\_\_\_\_\_

**\*(WHITE OR CAUCASIAN IS NOT AN ETHNICITY. Example: Irish, English, Spanish…)**

**DRUG OR FOOD ALLERGIES AND WHAT HAPPENS WHEN YOU ARE EXPOSED:**

­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NONE

**If you were outdoors in the summer at the hottest time of the day WITHOUT SUNSCREEN, would you (circle):**

Never tan, always burn (I) Sometimes tan, usually burn (II) Tan on average, sometimes burn (III)

Usually tan, rarely burn (IV) Mostly tan, almost never burn (V) Never burn (VI)

**Have you EVER (circle):** Blistered? Peeled?

# Do you use Sunscreen & if so, what type (with SPF) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Daily? Y N

**(STAFF ONLY)** Counseled on Sunscreen use? Y N

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List (or attach a list of) **ALL** current medications including aspirin, ibuprofen, herbal remedies (Ginko Biloba, St. John’s Wort), blood thinners, fish oils, vitamins, etc. Many medications, vitamins or herbs can increase bleeding and bruising.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries, please include cosmetic surgeries & year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Healthcare Provider**\***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\***Do we have permission to contact your primary healthcare provider? Y N

**Please Mark any Current (C) and/or Previously (P) Experienced Conditions:**

\_\_\_\_\_\_ Allergies to medications, foods, latex, topical products or other substances.   
 If **YES**, Please List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ Alpha/Beta Hydroxy Acid products in the last 2 weeks \_\_\_\_\_\_ Sun exposure in last 2 weeks

\_\_\_\_\_\_ Skin Infections

\_\_\_\_\_\_ Antibiotics

\_\_\_\_\_\_ Seizure History

\_\_\_\_\_\_ Pregnancy/Nursing

\_\_\_\_\_\_ Herpes or cold sores

\_\_\_\_\_\_ Accutane in last 12 months

\_\_\_\_\_\_ Blood Thinners

\_\_\_\_\_\_ Immunosuppressive agents (ie organ transplant)

\_\_\_\_\_\_ Skin Reaction to Band Aids

\_\_\_\_\_\_ Skin Reaction to Latex

\_\_\_\_\_\_ Retin A, Renova, salicylic acid, glycolic products in last 2 weeks

**Which concerns apply to you? (Check all that apply):**

* Unwanted Body Fat (stomach, flanks, arms…)
* Unwanted Hair
* Wrinkles (forehead, frown, crow’s feet…)
* Skin Laxity around mouth or eyes
* Upper Lip Lines
* Lip Shape or Size
* NasoLabial Folds
* Cheek & Cheekbone Flattening
* Leaking Urine
* Painful Intercourse
* Vaginal Dryness
* Dislike appearance of Labia (or outer genitalia)
* Poor Libido
* Hard Bumps Under Skin
* Enlarged Pores
* Clogged Pores
* Black/White heads
* Acne
* Excessive oiliness
* Under Eye Wrinkles or Darkness
* Scarring
* Rosacea
* Stretch Marks
* Cellulite
* Thinning Lashes
* Dark Spots (hyperpigmentation)
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**What is your Skin Type:** Dry Combination Oily Normal

**Have you ever had any of the following injectables or implants:**

Botox Xeomin Dysport Juvederm Restylane Perlane Bellafill (Collagen)

Sculptra (PLLA) Radiesse (Calcium hydroxyapatite) Versa+ Dermal Filler

What area(s) of the face/neck? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Mark any Services You Would like to Discuss or Have an Interest In:**

\_\_\_ **CoolSculpting:** Abdomen, flanks/bra fat, arms, submental, inner & outer thighs

\_\_\_ **ThermiSmooth** Skin Tightening (around eyes or mouth)

\_\_\_ **ThermiVA Vaginal Rejuvenation** (by Physician) \_\_\_ Medical grade Skin Peels

\_\_\_ Botox or Xeomin (by Physician) \_\_\_ Micro Needling (by Physician)

\_\_\_ Lip, Cheek, or Chin Augmentation \_\_\_ Physician Grade Skincare

\_\_\_ Fillers in General (by Physician) \_\_\_ **CoolTone** abdominal, gluteal, & thigh toning

\_\_\_ Minimally Invasive Laser Skin Resurfacing \_\_\_ **Hyperdilute Radiesse** for skin tightening &

\_\_\_ Laser Hair Reduction skin tone improvement of the neck, arms, etc…

***Thank you for taking the time to complete our Patient Intake form. With the following information, we will be better able to serve you. Our goal is to provide you with excellent service and results. At future visits, please let us know if any of the previous information changes. All information and treatments are confidential.***

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