

Aesthetic Patient Intake Forms

Personal Information		
Name		Home Phone
Address		Work / Mobile Phone
City		Prov / State
Zip Code		Date of Birth
Referred by		Sex: ___ Male ___ Female

Email Address: _____

Prior Aesthetic Treatments

Treatment Type	Last Treatment	Treatment Location
Laser Hair Removal	_____	_____
Laser Vein Removal	_____	_____
IPL for pigment or redness	_____	_____
CO2 or Fractional Laser	_____	_____
Microdermabrasion or Peel	_____	_____
Botox or Dysport	_____	_____
Dermal Fillers	_____	_____
Cosmetic Surgery Type	_____	_____

Past Medical History

Diabetes	Yes	No
Tattoos	Yes	No
Skin Cancer	Yes	No
Other Cancer	Yes	No
Heart trouble	Yes	No
Difficulty Healing	Yes	No
Bleeding tendency	Yes	No
Seizure Disorder	Yes	No
Neuromuscular Disorders	Yes	No

Current Medications

Allergies

Social History

Marital Status: _____

Alcohol?: Never Rarely
 Socially Daily

Tobacco? Never
 Previously, but quit
 Currently

Drugs? Never
 Currently

Type _____

Pregnant or Nursing? Yes No

Hobbies: _____

Occupation: _____

Sun Exposure: _____

Fitzpatrick Skin Type

(To be completed by staff)

I II III IV V VI