



Date: _____

Aesthetic / Wellness Intake Questionnaire

Patient Name _____ Age _____ Date of Birth _____

Address: _____

Phone (Home) _____ Phone (Work) _____

Phone (Cell) _____ Email _____

Referring Physician: _____

Primary Care Physician: _____

How did you hear about us? _____

Which body area/areas or condition would you like treated?

(For Women) are you or could you be pregnant? Yes / No _____

(For Women) are your menstrual periods normal? Yes / No _____

Do you have a history of Herpes I or II in the area to be treated? Yes / No _____

Do you have a history of keloid scarring? Yes / No _____

Have you taken Accutane or anticoagulants in the last 6 months? Yes / No _____

Do you have any permanent make-up, implants, or tattoos? Yes / No _____

Have you had any unprotected sun exposure, used tanning creams or tanning beds in the last 4-6 weeks? Yes / No _____

Hair Removal in the last 6 weeks (circle one) - shaving - tweezing - waxing - depilatories

Current skin care line



MEDICATION HISTORY

Please list all current **medications/herbs** and dosages

ALLERGIES:

____ No known allergies (**NKA**)

____ Allergies and Reactions to medication, foods, latex, other:

PAST SURGERIES OR HOSPITALIZATIONS:

Please list with date:

PAST AESTHETIC/MEDICAL COMSETIC PROCEDURES AND DATES:

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS (other current health problems):

Are you under a doctor's care? Yes / No

Describe _____



Do you now have or have you ever had:

Neurologic (seizures, headaches, weakness, paralysis) problems? Yes /No _____

Psychiatric problems? Yes /No _____

Depression? Yes /No _____

Head/Ear/Eyes/Nose/Throat Problems? Yes /No _____

Thyroid problems? Yes /No _____

Cardiac (heart) problems? Yes /No _____

Lung Problems? Yes /No _____

Breast Problem? Yes /No _____

Gastrointestinal (stomach) problems? Yes /No _____

Kidney or bladder disease? Yes /No _____

Liver problems? Yes No Kidney problems (stones, nephritis)? Yes /No _____

Hematological (bleeding, anemia) bleeding problems? Yes/ No _____

Diabetes (insulin dependent/oral medication) Yes /No _____

Musculoskeletal (bones, joints, muscles) problems? Yes /No _____

Circulation problems (varicose veins, thrombosis)? Yes /No _____

Cancer (Type: _____) Yes /No _____

High Blood Pressure Yes /No _____

OtherProblems_____

FAMILY HISTORY

Check illnesses which have occurred in any blood relative and write relationship to you:

___ Cancer _____

___ Bleeding Disorder _____

___ Heart disease _____

___ Diabetes _____

___ Others _____



SOCIAL HISTORY

Marital status: (please circle one) Single Married Widowed Divorced

Occupation: _____

Tobacco use: Yes / No Daily Amount _____ Number of years _____

Alcohol use: Yes / No Daily Amount _____ Number of years _____

Drug Use: Yes / No Daily Amount _____ Number of years _____

Caffeine Use: Yes / No Daily Amount _____ Number of years _____

Abuse (Describe):

Other: _____

Signature

_____/_____/_____

Date