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